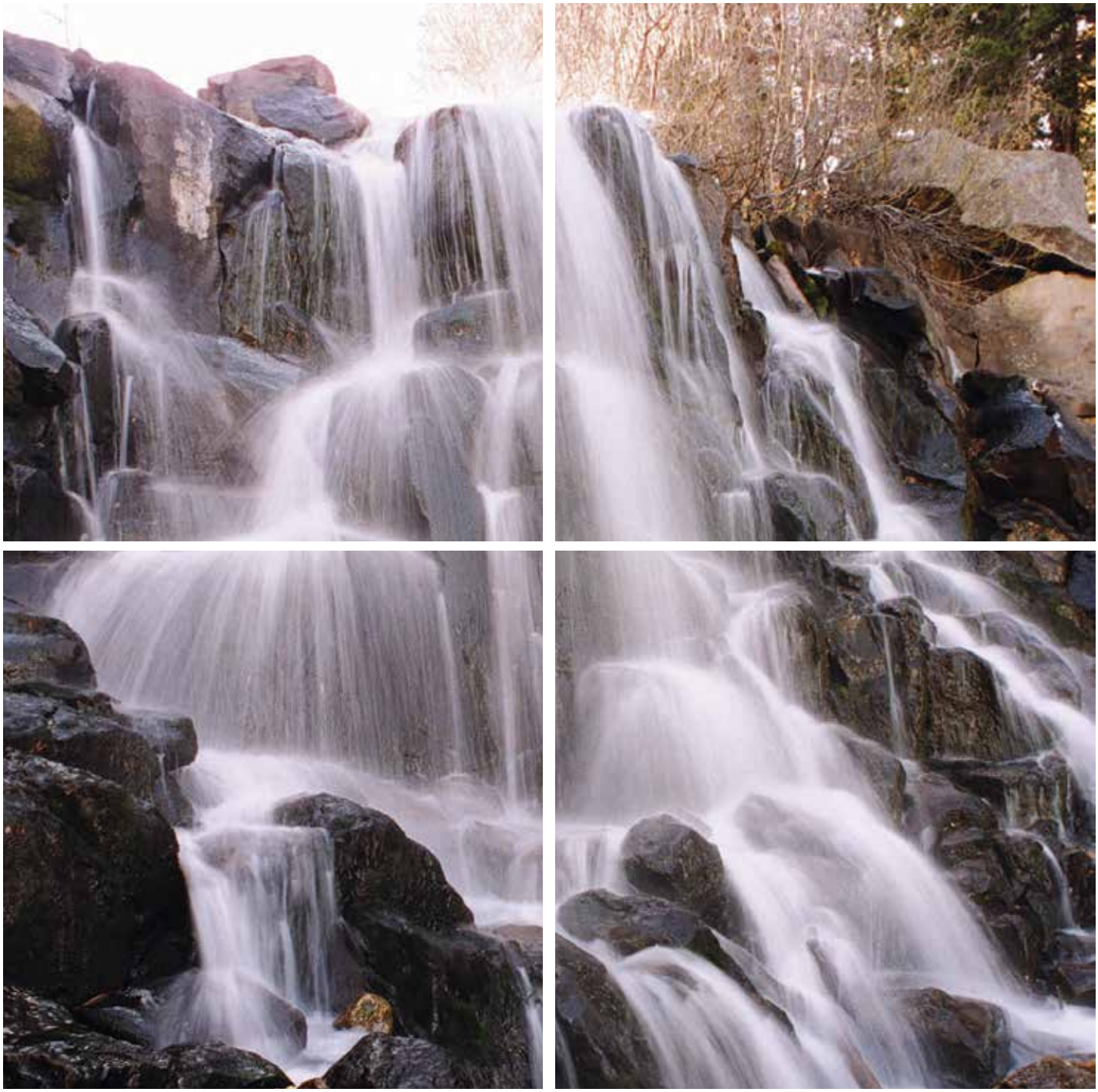
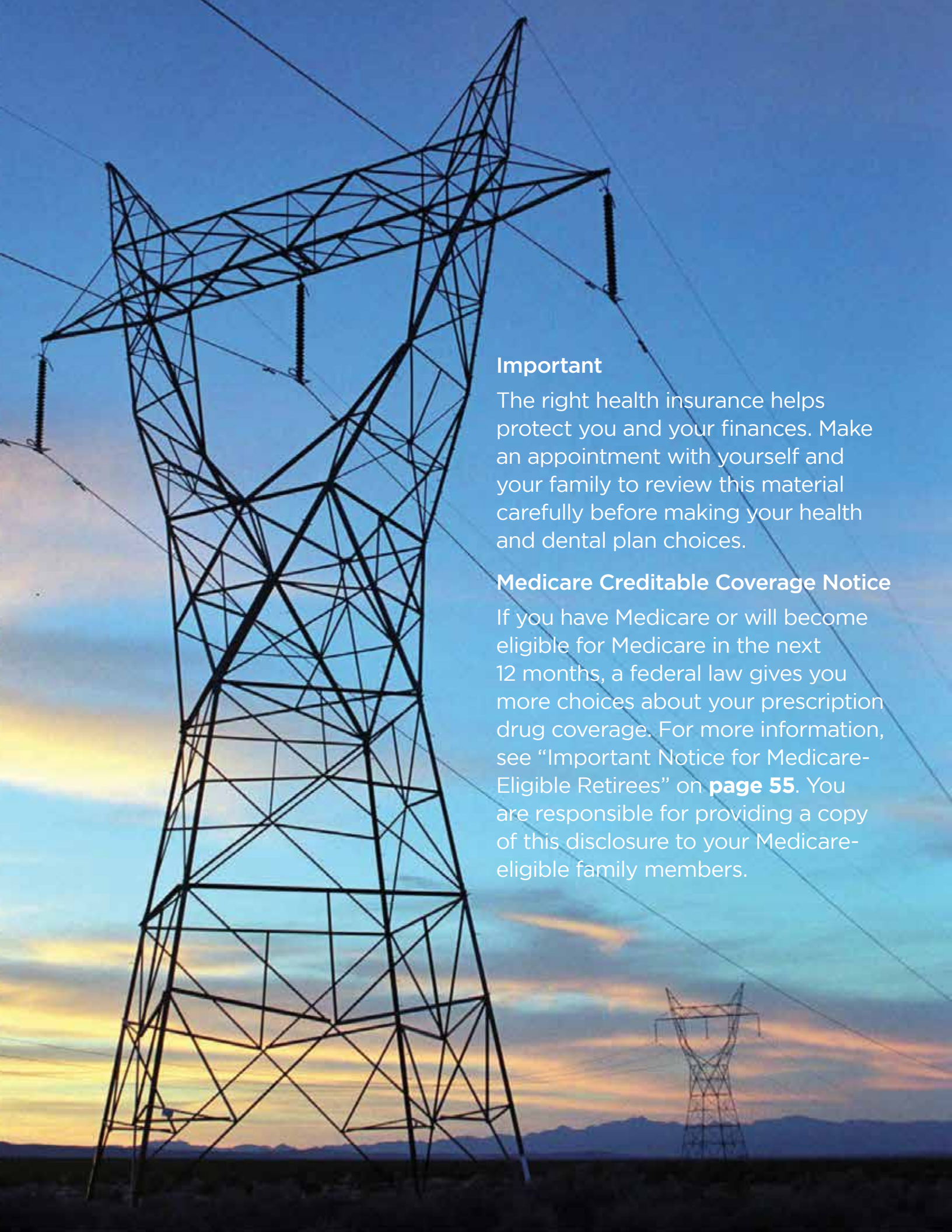
2018-2019 Retiree Benefit Guide



Los Angeles Department of Water & Power



Important

The right health insurance helps protect you and your finances. Make an appointment with yourself and your family to review this material carefully before making your health and dental plan choices.

Medicare Creditable Coverage Notice

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. For more information, see "Important Notice for Medicare-Eligible Retirees" on **page 55**. You are responsible for providing a copy of this disclosure to your Medicare-eligible family members.

Inside

Welcome

Health and Dental

Wellness Resources, Dependents and Medicare

Additional Information

This Guide represents a summary of the benefits available to you as an eligible retiree of the Los Angeles Department of Water & Power (LADWP). Every effort has been made to provide an accurate summary of the terms of the plans. To the extent there is a conflict between the information in this Guide and the official plan documents, the plan documents will govern in all cases. This Guide is for informational purposes only, and information contained herein may include programs that are not applicable to all retirees. Receipt of this Guide does not constitute a waiver of any applicable eligibility requirements nor does it constitute any employment promise or contract. Information contained in this Benefit Guide is subject to the approval of the Board of Water and Power Commissioners.

4 Exploring Your Retiree Benefits

We want you to select the plan that works best for you and your family. In this guide, you will find your options for enrollment, details on coverage, tips on how to enroll and more about your retiree benefits. Explore this guide so you can understand all that is available to you and make your best decision for coverage.

As an LADWP retiree, you are recognized and appreciated for your service. During your career, you demonstrated your attitude of empowerment serving Los Angeles every day. And now, we're empowering you to know more about your benefits so you can use them wisely and cost-effectively.

2018-2019 Open Enrollment

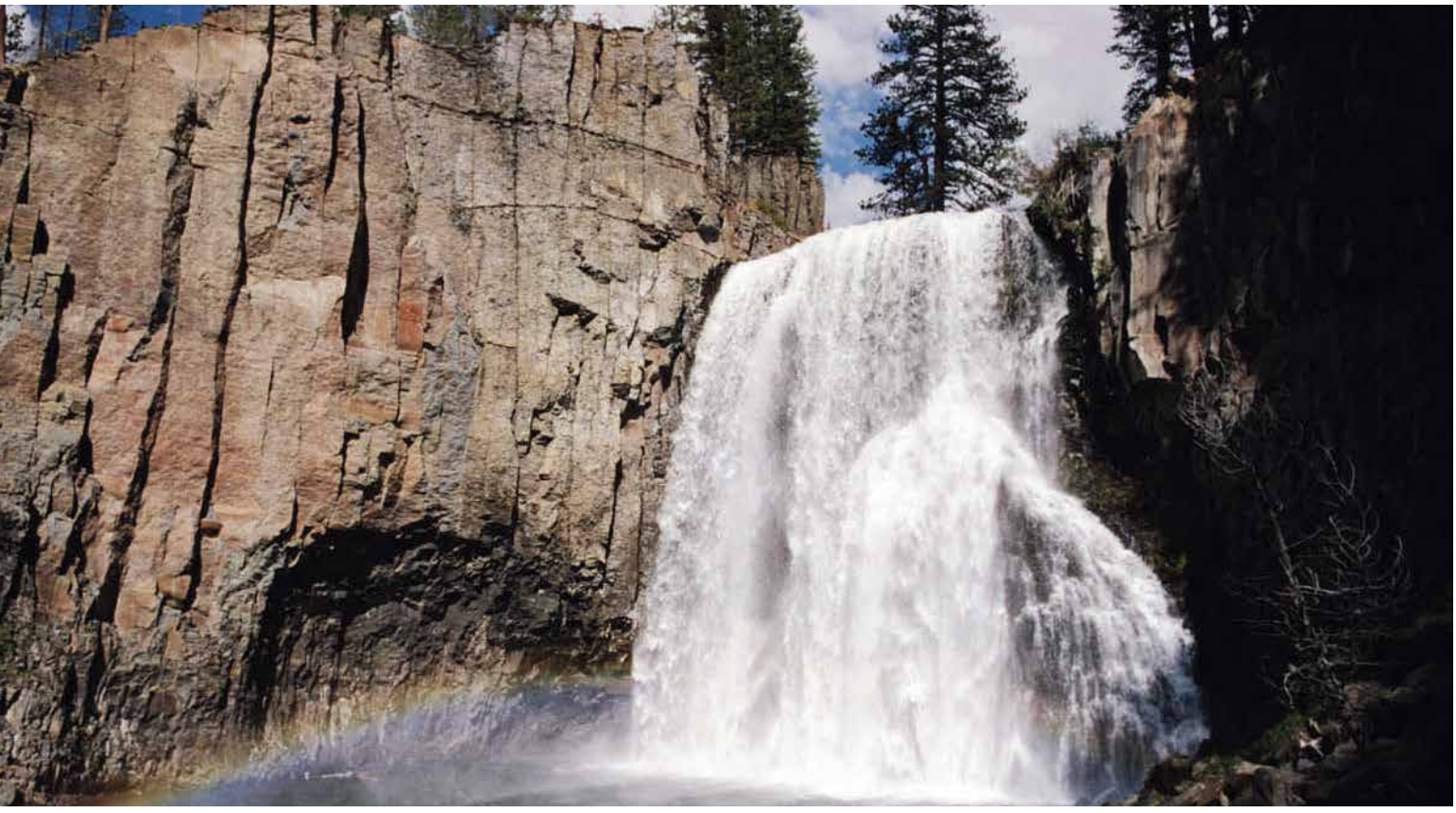
The open enrollment period is **April 23 to May 4, 2018**. This is your annual opportunity to make changes to your health and dental plans. Please read this guide to find out what's new with your 2018-2019 benefits.

Special Open Enrollment Saturday Event for Retirees

You are welcome to attend a special in-person enrollment session.

When: Saturday, April 28, 2018
from 8:00 a.m. to 12 Noon

Where: 111 North Hope Street, JFB A-Level
Los Angeles 90012.



Preparing for Enrollment or Enrollment Changes

Update your personal information: Make sure your address and other personal information is updated. If your address has changed, please notify the LADWP Health Plans Administration Office as soon as possible.

- **Note:** Retirees enrolled in an IBEW Local 18-sponsored health or dental plan should contact the IBEW Local 18 Benefit Service Center, or update their address online at **www.mybenefitchoices.com/local18**.

Review your dependents: Take a look at your current dependent coverage to ensure accuracy and to verify they still meet the eligibility criteria.

- You must update your dependents (such as a new spouse, domestic partner or a new child) within 31 days from a qualifying event, or you will not be able to change them until the next Open Enrollment period in 2019. See **page 15** for details.

Gather all of your documents: When you enroll, you will be asked to provide each eligible dependent's Social Security number for verification purposes. You will also be required to provide copies of dependent documentation (birth, marriage, domestic partnership). See **pages 17-19**.

Plan to keep proof of enrollment: Print or keep a copy of your form as proof of enrollment. Enrolling in and/or changing your benefits can't be done verbally.

- For LADWP-sponsored plans, you can enroll in person or by mail. See **page 8** for details.
- For IBEW Local 18-sponsored plans, you can enroll online. See **page 8** for details.

Please read this guide carefully to ensure you choose the health and dental plan that is best for you and your family. If you do not need to make any changes to your current health and/or dental plans, you do not need to do anything. Your current coverage choices will continue automatically. However, please review this guide for any benefit coverage changes.

Note: Please review the subsidy and premium rate changes for the 2018-2019 Plan Year.

Important

You must remove dependents from your coverage if they no longer qualify as "eligible dependents." See **pages 15-20**.

6 Eligibility

You are eligible for the LADWP-sponsored and/or IBEW Local 18-sponsored retiree plans if you:

- Are a LADWP retiree who is eligible to receive a minimum pension from the Water and Power Employees' Retirement Plan, and/or
- Were an employee of LADWP immediately prior to your retirement and you're receiving a monthly retirement allowance under the LADWP retirement plan.

Note: For IBEW Local 18-sponsored health and dental plans, you must be enrolled prior to retirement to participate.

If, as a retiree, you cancelled your IBEW Local 18-sponsored health and/or dental plan, you are now able to re-enroll in Local 18 plans during Open Enrollment.

For eligibility details about covering your eligible dependents (children, spouse or domestic partner), see **pages 15-20**.

What Applies To Me?

Employees who were hired prior to January 1, 2014 are considered "Tier 1" retirees. If you were hired by LADWP prior to January 1, 2014, all of the information in this guide, including subsidies, applies to you.

Employees who were hired on or after January 1, 2014 are considered "Tier 2" retirees. If you were hired by LADWP on or after January 1, 2014, the plan design information in this guide applies to you. However, your subsidies are different. If you are a Tier 2 retiree, the maximum subsidy you are eligible to receive for retiree health care benefits is at the self-only rate (Kaiser under age 65). For more information, please contact the LADWP Health Plans Administration Office at **(213) 367-2023** or **(800) 831-4778**.

Pre-65 exclusive details
Are you under age 65? Look for information by this symbol throughout the guide.

Post-65 exclusive details
Are you age 65 or over? Look for information by this symbol throughout the guide.

Enrolling in Coverage

During Open Enrollment, you will have the opportunity to review your benefits and make any needed changes. You do not have to take action if you wish to maintain your current benefits, eligible dependents and coverage levels.

Any changes made during Open Enrollment are effective July 1, 2018 for the 2018-2019 Plan Year. The Plan Year is July 1, 2018 to June 30, 2019, however, the health and dental plans are calendar-year-based, meaning benefits that have a specified number of visits per year, or amounts you pay for deductibles, coinsurance or copayments and when you reach your annual out-of-pocket maximum, are all counted or accumulate on a calendar-year basis.

Coverage for a New Retiree

Coverage for a new retiree is effective one month after your retirement date (e.g., if you retire on August 1, 2018, your active coverage ends on August 31, 2018 and your retiree coverage begins on September 1, 2018).

8 How to Enroll

LADWP-Sponsored Plans

To enroll in a LADWP-sponsored plan, you can pick up, call or download your enrollment/change form. Once your form is completed, submit it and the supporting documentation to:

LADWP Health Plans Administration Office
111 North Hope Street, Room 564
Los Angeles, CA 90012

- You can log on and download enrollment forms from the eBenefits website at **https://eBenefits.ladwp.com**.

IBEW Local 18-Sponsored Plans

Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.

To enroll, view current enrollment, make changes or cancel benefits, go to **www.mybenefitchoices.com/local18** and register (if you have not done so already) and complete the enrollment wizard. Once finished, you will receive an email with a benefit summary to review. Please review the summary to ensure it displays 100% complete and that your selections and dependent(s) information is correct. Social Security number, birth and marriage certificates and all pending document are required to complete your enrollment.

If you need more information, call the IBEW Local 18 Benefit Service Center at **(800) 842-6635** weekdays from 8:30 a.m. – 12:00 p.m. and from 12:45 p.m. – 5:00 p.m.

Reviewing Your IBEW Local 18-Sponsored Plan Choices

Print your confirmation statement at the end of the enrollment process. Check your enrollment carefully!

- Coverage level — did you elect individual or family coverage?
- Dependents — do you have the correct name and Social Security number listed for each dependent you want to cover? If you added a new dependent, did you submit the verification of eligibility information listed on **pages 17-19**?
- Your contributions — does your paycheck stub accurately reflect your benefit choices?

See pages 15-20 for details about which dependents you may enroll and when their coverage begins and ends.

Which Dependents Can You Cover?

- Your spouse or domestic partner
- Your children under age 26 — includes stepchildren and children of whom you are their legal guardian
- Your disabled children age 26 or older
- Your grandchildren who are the children of your covered children

Special rules and definitions apply to all dependents. It is your responsibility to remove dependents from coverage if they no longer qualify as "eligible dependents." See dependent eligibility details on **pages 15-20**

Pre-65 and Post-65 Additional Enrollment Details

If you will be turning 65 within three months, you must enroll in Medicare and provide proof of coverage. See pages 49-56 for Medicare details.

- **LADWP-sponsored plan:** Before age 65, you and your eligible dependent(s) must enroll in **Medicare Part B** and provide proof of enrollment to avoid losing your LADWP-sponsored health plan.
- **IBEW Local 18-sponsored plan:** Before age 65, you and your eligible dependent(s) must enroll in **Medicare Parts A and B** and provide proof of enrollment to avoid losing your IBEW Local 18-sponsored health plan. (Dependents are not required, by the plan, to have Medicare Parts A and B until the retiree is 65.)

The Health Insurance Marketplace

You've probably heard about the Health Insurance Marketplace or "exchange." In California, it's called **Covered California™**. Some states, like California, run their own Marketplace, and some rely on the one run by the federal government. Each state is different, and you can link to your state's Marketplace by going to **www.HealthCare.gov**. If you are under age 65, you may choose a Marketplace plan instead of enrolling in an LADWP-sponsored or IBEW Local 18-sponsored health plan.

Important notes: If you decide to enroll in a health plan through the Marketplace, please be aware that:

- LADWP will not pay any part of your premiums.
- You will pay for this coverage directly.
  - You may qualify for tax credits and/or subsidies to help you pay the premiums of your Marketplace plan. However, because LADWP and IBEW Local 18-sponsored health plans meet ACA requirements, you likely will not be eligible for the credits and subsidies even if you fall within the income requirements.
- LADWP will not reimburse you for any payments made to the Marketplace for health insurance.
- If you drop Marketplace coverage, you will not be allowed to re-enroll in a LADWP-sponsored health plan until the next Open Enrollment period unless you have a qualifying event.

By age 65, you must be enrolled in these Medicare plans, and show proof of enrollment, to avoid losing your LADWP- or IBEW Local 18-sponsored health plan. If you are 65 or older and you or your spouse/domestic partner fail to enroll in or maintain your Medicare coverage, you may incur additional fees. See **pages 49-56** for Medicare details.

Note: Retirees over the age of 65 cannot enroll through the Health Insurance Marketplace.

- **LADWP-sponsored health plan:** You must be enrolled in Medicare Part B.
- **IBEW Local 18-sponsored health plan:** You must be enrolled in Medicare Parts A and B.
  - For IBEW Local 18-sponsored Anthem Blue Cross Owens Valley: This plan is not available when you reach age 65.

Pre-65 exclusive details **Post-65 exclusive details**

10 Qualifying Events

Making Coverage Changes During the Year

You can only change your health and/or dental plans outside of the Open Enrollment period if you experience an eligible qualifying life event. You must act quickly if you need to add or delete an eligible dependent based on one of the qualifying events outlined in the table below.

For LADWP-sponsored plans, contact the Health Plans Administration Office at **(213) 367-2078** or **(800) 831-4778**.

For IBEW Local 18-sponsored plans, go to **www.mybenefitchoices.com/local18**, log in and make your qualifying life event changes online. Required supporting documentation can also be uploaded online. If you have any questions, please call the IBEW Local 18 Benefit Service Center at **(800) 842-6635**.

You can log on and download enrollment/change forms:

- LADWP-sponsored coverage: **https://eBenefits.ladwp.com**
- IBEW Local 18-sponsored coverage: **www.mybenefitchoices.com/local18**

31 Days

Be sure to submit your completed enrollment/change form and supporting documentation within **31 days** from your qualifying event.

Qualifying Events

Be sure to submit your completed enrollment/change form and supporting documentation within **31 days** from your qualifying life event to the appropriate plan administrator (LADWP or IBEW Local 18).

If You...	You Should
Get married	Add your new spouse to your plan(s) within 31 days from your wedding date, and submit a copy of your marriage certificate with your change form. Coverage will be effective on the first of the month following the date yousubmit an enrollment/change form to the appropriate plan administration (LADWP or IBEW Local 18).
Want to add a spouse and/or eligible other dependent who has lost other health and dental coverage	Add the spouse and/or eligible dependent who loses coverage for one of the following reasons within 31 days from the date coverage was terminated: ▸ Loss of eligibility (such as termination of employment, death, divorce or reduction in the number of hours of employment), or ▸ Loss of employer's contribution toward coverage. Submit with the enrollment/change form a certificate or letter from the employer giving the last day of coverage and the reason for the loss of coverage.
Want to add an eligible dependent up to age 26 who has lost coverage	Add the eligible dependent within 31 days of the qualifying event, and provide a copy of the child's birth certificate with the enrollment/change form when you first enroll the eligible dependent, plus a certificate or letter from the employer giving the last day of coverage and the reason for the loss of coverage.
Want to add your domestic partner and your domestic partner's eligible child(ren) once you have lived together for 12 months	Add your domestic partner and your domestic partner's child(ren) within 31 days from the end of the 12-month period. A domestic partner's child can only be covered if the domestic partner is also covered. For more information on domestic partner eligibility, see the *Dependent Eligibility At-A-Glance* chart starting on **page 17**.

Qualifying events, continued

If You...	You Should
Were covered by other health and dental insurance, for example, by a spouse's employer, then lost coverage. Loss of other coverage is limited to the following reasons: ▶ COBRA continuation coverage was exhausted ▶ Coverage was terminated because of loss of eligibility as a result of legal separation, divorce, spouse's death or termination of spouse's employment ▶ Spouse's employer contribution toward coverage was terminated	Enroll in coverage through LADWP when the other coverage ends, provided that you request enrollment within 31 days of your coverage ending.
Have a baby	▶ Add a newborn child to your plan(s) within 31 days from the date of birth to ensure that there will be no lapse of coverage for your newborn. To enroll your newborn, submit an enrollment/change form to the appropriate plan administration (LADWP or IBEW Local 18). If you do not enroll the newborn within 31 days, you must wait until the next Open enrollment period to add the newborn. ▶ If court-ordered paternity has recently been determined, you may add the child within 31 days from court award with proof of paternity. ▶ If your covered eligible dependent child has a baby, you can add that grandchild to your health and dental plans within 31 days from the date of birth. Please note that any medical expenses incurred by the newborn prior to the effective enrollment date are the responsibility of the retiree.
Adopt a child	Add an adopted child to your plan within 31 days from placement. Submit copies of the adoption papers with your enrollment/change form.
You or your spouse becomes the legal guardian of a child	Add the child to your plan within 31 days from the date of the court order placing the child in your guardianship. Submit copies of the court order with the enrollment/change form.
Are a retiree enrolled in a Kaiser, Anthem Blue Cross, UnitedHealthcare, Health Plan of Nevada, Guardian DHMO Dental or United Concordia Plus Dental plan who moves out of these plans' service areas (UnitedHealthcare PPO Plan is nationwide)	Re-enroll in another plan that is within the new service area you will be moving to within 60 days from the date you establish residency at the new address.
Are a retiree enrolled in Anthem Blue Cross HMO, who moves out of state	Contact the IBEW Local 18 Benefit Service Center at **(800) 842-6635** for information on the Anthem Blue Cross out-of-state plans.

Cancelling Coverage

If you are currently enrolled in an LADWP-sponsored plan, you must call the LADWP Health Plans Administration Office at **(213) 367-2023** or **(800) 831-4778** to obtain the form to cancel your coverage.

- You can log on and download a cancellation form from the eBenefits website at **https://eBenefits.ladwp.com**.

To cancel coverage in an IBEW Local 18-sponsored plan, please contact the IBEW Local 18 Benefit Service Center at **(800) 842-6635** or **(818) 678-0040** to obtain the form to cancel your coverage.

- You can log on and download a cancellation form from the IBEW Local 18 Benefit Service Center website at **www.mybenefitchoices.com/local18**.

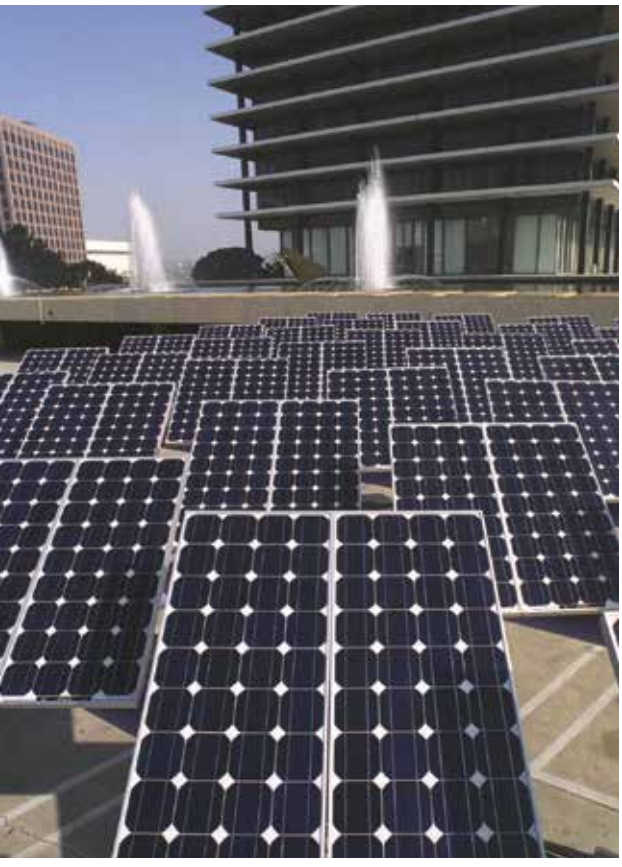
Your Coverage Options

Health Plans

LADWP and IBEW Local 18 sponsor both health maintenance organization (HMO) plans and preferred provider organization (PPO) plans. Each plan offers you access to its own network of health care providers — hospitals, clinics and physicians — and administers the claims that you and other members submit for the care you receive.

Which plan is right for you? If you prefer to have your care coordinated through a single doctor, an HMO plan might be right for you. If you want greater flexibility or if you see a lot of specialists, a PPO plan might be a better option.

You can compare coverage of the various plans in the comparison charts on pages 27-44 of this guide.



LADWP-Sponsored Plans

- Kaiser/Senior Advantage HMO
- UnitedHealthcare PPO Plan A
- UnitedHealthcare PPO Plan B
- UnitedHealthcare PPO Plan C
- UnitedHealthcare Medicare Advantage HMO (formerly Secure Horizons)
- Health Plan of Nevada/Senior Dimensions HMO

IBEW Local 18-Sponsored Plans

- Anthem Blue Cross HMO
- Anthem Blue Cross PPO Plan
- Anthem Blue Cross Prudent Buyer Plan (Owens Valley retirees only, under 65)

Understanding HMO Plans

HMOs cover only the care you receive from their provider networks, except for emergency care. If you want to use a specific provider for your care, be sure to verify that provider is in the HMO's network.

If you do not live in an HMO's network area, you should not enroll in that HMO's plan. If your covered eligible dependents live outside of the HMO's network area, they will have limited coverage, typically for emergencies only. IBEW Local 18-sponsored plans may have additional coverage if your eligible dependent is set up under Guest Membership.

You pay a **co-pay** (fixed dollar amount) when you receive care. Providers file claims for you, which helps eliminate paperwork.

Understanding PPO Plans

PPOs cover care you receive from their provider networks (in-network care), but they also cover care you receive from other providers (non-network care). However, your benefits are paid at the highest level when you use a provider in your PPO network.

The PPOs have an **annual deductible** for most health care expenses. You are responsible for paying your eligible health care expenses until you reach your annual deductible.

After you meet the deductible, you pay a percentage of the covered expense; this is called a **coinsurance** amount. The PPO pays the remainder of your covered expenses.

If your coinsurance amounts reach your **annual maximum**, the PPO pays 100% of your covered expenses for the rest of the calendar year.

You may be responsible for paying a fixed **co-pay** for certain provider visits. In some instances, you may have to meet the deductible before you can just pay a co-pay for services you receive and in almost all instances, the co-pays do count towards the annual out-of-pocket maximums. Consult the plan Certificate or Evidence of Coverage (COC or EOC) for exact details.

Note: Preauthorization may be required for certain types of care. If you use an out-of-network provider, you will be responsible for amounts exceeding eligible medical expenses, and you may be required to file claims for expenses incurred.

Prescription Drug Coverage

Benefits for prescription drugs are included with your health plan choice.

How Your Prescription Coverage Works

Your prescription drug coverage varies based on the health plan in which you enroll. All plans offer you the convenience of filling your prescription at a retail pharmacy (or Kaiser-based pharmacy on the Kaiser HMO Plan) and ordering a longer-term supply through mail order, which can be useful if you take a maintenance medication.

Once you select a plan, you can learn more about your options for filling your prescriptions from the provider's website. Highlights of the prescription drug plans are listed in the Health Plan Comparison Charts.

Did you know? The prescription drug coverage in LADWP and IBEW Local 18-sponsored health plans is often better than most Medicare Part D plans available to Medicare-eligible individuals.

Dental Plans

Similar to health care options, for dental care you can choose between a dental health maintenance organization (DHMO) and a preferred provider organization (PPO).

Understanding DHMO Plans

DHMOs cover only the care you receive from their provider networks, unless you need emergency care outside the plan's service area. If you do not live in a DHMO's network area, you should not enroll in that DHMO's plan.

Understanding PPO Plans

A dental PPO gives you the choice of using in-network or out-of-network dentists. You will generally pay more if you use out-of-network dentists.

All plans offer 100% coverage for diagnostic and preventive services. You can find a comparison of the dental plans in the Health Plan Comparison Charts.

Note: If you have Delta Dental coverage when you retire, you must choose a new plan in order to continue your dental coverage. If you do not change plans, you will not be able to enroll in a new dental plan until the next Open Enrollment period.

IMPORTANT: Retirees who receive a Notice of Premium Due billing notice for a premium surcharge for Medicare Part D are responsible for paying the premium surcharge. Failure to pay the surcharge amount on the billing notice will result in a loss of coverage. LADWP does not pay the Medicare Part D premium surcharge. Medicare Part D enrollment does not apply to IBEW Local 18-sponsored plans.

You should not enroll in an individual Medicare Part D Prescription Drug Plan if you are enrolled in a LADWP or IBEW Local 18-sponsored health plan. If you enroll in a Medicare Part D plan on your own, you will lose your LADWP-sponsored or IBEW Local 18-sponsored prescription drug and medical coverage as well as your LADWP subsidy.

LADWP-Sponsored Plans

- United Concordia Plus Dental Plan (DHMO)
- United Concordia Preferred Dental Plan (PPO)

IBEW Local 18-Sponsored Plans

- Guardian Dental Plan (PPO)
- Guardian Dental Plan (DHMO)

Covering Your Eligible Dependents

If you elect coverage for yourself, you may also elect the same coverage for your eligible dependents. When you elect coverage for an eligible dependent, you will be asked to provide each eligible dependent's Social Security number along with all required documentation to verify eligibility. Failure to provide this information may result in loss of benefits. See the charts starting on page 17 for more details.

You can elect the same coverage for your:

- Lawful spouse
- Registered domestic partner
- Nonregistered domestic partner

Covering Your Spouse or Domestic Partner

To elect coverage for your spouse or domestic partner, you must submit to the appropriate plan administrator (LADWP or IBEW Local 18) the documentation listed on **pages 17-19** to establish eligibility. After you submit the required documentation, you should follow up with the appropriate plan administrator to ensure it was accepted and to determine when the coverage will be effective.

The Affidavit of Domestic Partnership – Health and Dental Enrollment form authorizes your domestic partner to receive your health care benefits only. For your retirement benefits, you must file a separate affidavit with the Retirement Office.

For domestic partner coverage for Health Plan of Nevada, you must complete a Domestic Partner Rider form.

Tax Implications

If you cover your domestic partner and his or her children under your coverage, you will pay income tax on the amount of the health and/or dental plan subsidy that LADWP pays for their coverage. However, if you and your domestic partner are in a California-recognized domestic partnership, you won't have to pay California state income tax on this subsidy.

If You Marry Your Domestic Partner

If you're in a domestic partnership and you marry your domestic partner, you need to submit a copy of your certified marriage certificate, an enrollment/change form, and a Termination of Domestic Partnership form to the appropriate plan administrator (LADWP or IBEW Local 18) within 31 days from the date of marriage. If you don't submit the necessary documents, you will continue to pay income taxes on the subsidy for your domestic partner's coverage and any coverage for his or her children.

If You and Your Spouse or Domestic Partner Divorce/End Partnership

If you and your spouse divorce, or you and your domestic partner terminate your domestic partnership, you must notify the appropriate plan administrator (LADWP or IBEW Local 18) by completing an enrollment/change form and, upon request, providing proof of the divorce/termination of domestic partnership within 31 days after the divorce/termination of domestic partnership is finalized. If you don't:

- You will be billed for any services incurred by your ex-spouse/ex-domestic partner, and
- You will continue to be taxed for your domestic partner.
- Your ex-spouse's COBRA rights will be forfeited. See **pages 57-60** for more information on COBRA Continuation Coverage.

Your ex-spouse's/ex-domestic partner's coverage will end on the first day of the month after the forms are received.

Improper Use of Benefits

Retirees who receive benefits for themselves or their ineligible dependents from an LADWP-sponsored or IBEW Local 18-sponsored health or dental plan based on a false, deceptive or otherwise improper act may have their health or dental plan cancelled and may be considered ineligible for enrollment in LADWP-sponsored or IBEW Local 18-sponsored health and dental plans. In addition, retirees will be billed for any LADWP subsidy paid for ineligible dependents.

Covering Your Eligible Dependent Children

Children considered eligible dependents include your:

- Biological children
- Stepchildren
- Legally adopted children
- Children for whom you and/or your spouse are the legal guardian
- Children of your domestic partner (if you also cover your domestic partner)
- Grandchildren (if they are the children of your covered child)

To be your "eligible dependent," your child(ren) must be:

- Under 26 years of age, or
- 26 years of age or older and wholly unable to engage in any gainful occupation due to a mental or physical disability that was established and certified as a disability before age 26 through the health care provider. A copy of the certification must be provided to the appropriate plan administrator (LADWP or IBEW Local 18).

To cover your dependent child, you must submit the required documentation, listed on **pages 18-19**, to the appropriate plan administrator (LADWP or IBEW Local 18). The effective date is the first of the following month after submission.

Grandchildren

You can cover a grandchild under your health and dental plans only if the grandchild is the child of your covered eligible dependent and meets eligibility requirements listed in the chart on **page 19**.

Surviving Eligible Dependents

Upon your death, your surviving spouse or domestic partner and/or surviving children may continue coverage if they:

- Are eligible to receive a monthly allowance under the Water and Power Employees' Retirement Plan, and
- Were covered as eligible dependents on your health plans at the time of your death.

In order to continue coverage, your surviving spouse or domestic partner must enroll in an LADWP-sponsored or IBEW Local 18-sponsored health plan within 60 days from your death. **If they do not enroll within this time frame, they will lose eligibility for surviving dependent coverage, and will not be eligible to enroll at a later date.**

There are a few important points to consider about surviving dependent coverage:

- The retiree premium rates are used to determine the health premium for surviving dependent(s).
- While surviving dependent(s) can enroll in dental coverage, the dependent will pay the full cost of coverage — there is no subsidy.

Dependent Eligibility At-A-Glance

When you elect coverage for an eligible dependent, you must provide each dependent's Social Security number along with all of the required documentation described in this chart.

Dependent Type	Age Limit	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse	N/A	Person to whom you are legally married	> Social Security number > A copy of a certified marriage certificate
Registered domestic partner	N/A	Meet LADWP's eligibility requirements as listed here	> Social Security number > Your Declaration of Domestic Partnership issued by the California Secretary of State, or > An equivalent document issued by: — A local California agency, — Another state, or — A local agency within another state

Dependent Type	Age Limit	Eligibility Definition	Documents Required for Verifying Eligibility
Nonregistered domestic partner	N/A	Meet LADWP's eligibility requirements as listed here	> Social Security number > Copies of your — and your domestic partner's — California driver's licenses or identification cards that show you share the same address and that it matches your address of record with LADWP, or other acceptable written verification showing that you and your domestic partner have been living at the same address for the last 12 months, and > The Affidavit of Domestic partnership – Health and Dental Enrollment form provides proof that you and your domestic partner meet LADWP's required criteria, including: — Neither of you was married, in another domestic partnership, or covered a spouse or domestic partner during the previous 12 months. — You have lived together for the previous 12 months. — You are both at least 18 years old. — You and your domestic partner are not related by blood closer than would bar marriage in the state of California.
Biological child	Up to age 26[1]	Minor or adult child(ren) of retiree who is under age 26	> Social Security number > A copy of the child's birth certificate
Stepchild	Up to age 26[1]	Minor or adult child of retiree's spouse who is under age 26	> Social Security number > A copy of the child's birth certificate
Child legally adopted/ ward, including grandchild(ren) of whom you have legal custody	Up to age 26[1]	Minor or adult child who is under age 26 and legally adopted/ward by retiree	> Social Security number > Court documentation > A copy of the child's birth certificate

Dependent Eligibility At-A-Glance, continued

Dependent Type	Age Limit	Eligibility Definition	Documents Required for Verifying Eligibility
Child of domestic partner	Up to age 26[1]	Minor or adult child of retiree's covered domestic partner who is under age 26	> Social Security number > A copy of the child's birth certificate > Proof of domestic partnership
Disabled child	Over age 26	Child 26 years of age or older and wholly unable to engage in any gainful occupation due to a mental or physical disability that was established and certified as a disability before age 26 through the health care provider. A copy of the certification must be provided to the appropriate plan administrator (LADWP or IBEW Local 18)	> Social Security number > A copy of the child's birth certificate and proof of the child's disability must be established before the child turns 26 > In addition, you may be required to submit documentation directly to your health care plan carriers: — Kaiser: Complete a Special Disabled Dependent Application — Anthem Blue Cross and Guardian: Contact the IBEW Local 18 Benefit Service Center for any required documentation — All other carriers: Contact the carrier's member services for any required documentation
Grandchildren	Up to age 26[2]	Your grandchildren can be added to the plan if they are children of your covered children	> Social Security number > A copy of the child's birth certificate

[1] Eligibility continues through the end of the month your eligible dependent turns age 26.
[2] When dependent's parent turns age 26, eligibility will continue through the end of the month.

When Coverage Ends for Your Eligible Dependents

This chart shows when coverage ends for your eligible dependents. It also outlines the documentation that you must provide to the appropriate plan administrator (LADWP or IBEW Local 18).

If You Cover Your...	Reasons to End Dependent Coverage	How To End Dependent Coverage	What Happens if You Fail to Notify Health Plan Providers
Spouse	Your divorce is final	Complete an enrollment/ change form and provide proof of the divorce before the first of the month after divorce is final.	You will be billed for any services incurred by your former spouse; COBRA rights for your former spouse will be forfeited.
Registered and or nonregistered domestic partner	You terminate your domestic partnership	Provide a completed Termination of Domestic Partnership form and enrollment/change form before the first of the month after dissolution of the partnership.	You will be billed for any services incurred by your former domestic partner and continue to pay income tax on the health and dental plans.
Children	At the end of the month the child reaches age 26	Coverage is automatically terminated.	
Dependent grandchildren	The grandchild's parent is no longer eligible	Coverage is automatically terminated.	
Surviving children under family death benefit	The child reaches 18	Coverage is automatically terminated.	

Note: When coverage for your spouse, children, grandchildren or surviving children ends, they will be eligible to elect continuation coverage under COBRA, unless they have forfeited their COBRA rights. For more details about COBRA, see **pages 57-60**.

Paying for Coverage

Health and Dental Plan Pay Periods

When you enroll in a health and/or dental plan, your portion of the cost will be deducted from your retirement check the month prior to when coverage is applied.

For example, to pay for March premiums, deductions will be taken during the pay period ending February 28. Deductions will be taken by March 31 to pay for April premiums, continuing with a similar structure for each month of the year. Use this chart as a cheat sheet for the deduction schedule:

Deduction Taken For Period Ending	Pay Health/Dental Premium For
January 31	February
February 28	March
March 31	April
April 30	May
May 31	June
June 30	July
July 31	August
August 31	September
September 30	October
October 31	November
November 30	December
December 31	January

Health Plan Subsidy

If you are a retiree receiving a "Formula Pension" from the Water and Power Employees' Retirement Plan, you are eligible for a health plan subsidy. LADWP's health plan contribution is based on a formula accounting for years of service as a member of the retirement plan and age at retirement. The information is determined by the Retirement Plan Office.

The maximum health subsidy for the 2018-2019 Plan Year is: Tier 1 at $1,751.18 and Tier 2 at $875.59.

If you are the eligible spouse of a deceased retiree, you are eligible to receive the subsidy that would have been given to the deceased retiree if he or she were still living, if the eligible spouse was enrolled in the deceased retiree's health or dental plan at the time of the member's death and is eligible to receive a monthly allowance.

Dental Plan Subsidy

If you are a retiree receiving a "Formula Pension" from the Water and Power Employees' Retirement Plan, you are eligible for a dental plan subsidy. Spouses or surviving dependents are not eligible for the LADWP dental plan subsidy.

Health and dental subsidies can only be used for LADWP-sponsored or IBEW Local 18-sponsored health and dental plans; the contribution cannot be used for private insurance plans, the Marketplace or for plans of outside organizations.

Rate and Subsidy Charts

Rates are effective July 1, 2018 through June 30, 2019.[1]

Rates for 2018-2019 LADWP-Sponsored Health Plans

For Kaiser, UnitedHealthcare (UHC) and Health Plan of Nevada (HPN) retiree plans.

Coverage Level	UHC Option A	UHC Option B	UHC Option C	Kaiser/SR Advantage	UHC Medicare Advantage HMO[2]	HPN/SR Dimensions
Retiree Under Age 65						
Self Only	$1,434.40	$1,244.91	$968.92	$875.59	$1,488.90	$1,218.94
Self + 1 dependent under 65	$2,868.87	$2,489.87	$1,937.87	$1,751.18	$3,072.59	$2,442.56
Self + 2 or more dependents under 65	$3,757.21	$3,260.85	$2,537.94	$2,477.91	$3,370.86	$3,412.96
Self + 1 dependent enrolled in Medicare Parts A & B	$2,039.50	$1,692.20	$1,238.84	$1,219.82	$1,951.81	$1,513.14
Self + 1 dependent enrolled in Medicare Part B	$2,508.71	$2,047.55	$1,488.80	$1,531.82	$2,761.43	$2,442.56
Retiree Over Age 65 and Etnrolled in Medicare Parts A & B						
Self Only	$605.10	$447.29	$269.92	$344.23	$462.91	$289.52
Self + 1 dependent under 65	$2,039.50	$1,692.20	$1,238.84	$1,219.82	$1,951.81	$1,513.14
Self + 2 or more dependents under 65	$2,927.91	$2,463.23	$1,838.94	$1,946.55	$2,344.87	$2,483.54
Self + 1 dependent enrolled in Medicare Parts A & B	$1,210.20	$894.58	$539.84	$688.46	$925.82	$579.04
Self + 1 dependent enrolled in Medicare Part B	$1,679.41	$1,249.93	$789.80	$1,000.46	$1,735.44	$1,513.14
Retiree Over Age 65 and Enrolled in Medicare Part B Only						
Self Only	$1,074.31	$802.64	$519.88	$656.23	$1,272.53	$1,218.94
Self + 1 dependent under 65	$2,508.71	$2,047.55	$1,488.80	$1,531.82	$2,761.40	$2,442.56
Self + 2 or more dependents under 65	$3,397.12	$2,818.58	$2,088.90	$2,258.55	$3,154.50	$3,412.96
Self + 1 dependent enrolled in Medicare Parts A & B	$1,679.41	$1,249.93	$789.80	$1,000.46	$1,735.44	$1,513.14
Self + 1 dependent enrolled in Medicare Part B	$2,148.62	$1,605.28	$1,039.76	$1,312.46	$2,545.06	$2,442.56

[1] The rates are subject to the approval of the Board of Water and Power Commissioners.

[2] Effective July 1, 2018, the Medicare rates through UnitedHealthcare Medicare Advantage renew on a plan-year basis. As a result, those retirees enrolled in a Medicare tier will no longer receive a rate adjustment on January 1, 2019.

[3] Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.

Rates for 2018-2019 IBEW Local 18-Sponsored Health Plans

For Anthem Blue Cross retiree plans.

Retirees must be enrolled in Anthem Blue Cross prior to retirement to participate in the plan. If as a retiree you cancelled your IBEW Local 18-sponsored medical plan, you are now able to re-enroll into an IBEW Local 18-sponsored plan.

Coverage Level	Anthem Blue Cross HMO (Local 18)[3]	Anthem Blue Cross PPO (Local 18)[3]	Anthem Blue Cross Owens Valley (Local 18)[3]
Retiree Under Age 65			
Self Only	$1,518.83	$1,716.26	$1,844.50
Self + 1 dependent under 65	$1,797.80	$2,179.43	$3,841.73
Self + 2 or more dependents under 65	$1,850.63	$2,699.38	$4,765.66
Self + 1 dependent enrolled in Medicare Parts A & B	$1,797.80	$2,179.43	$3,841.73
Self + 1 dependent enrolled in Medicare Part B	$1,797.80	$2,179.43	$3,841.73
Retiree Over Age 65 and Enrolled in Medicare Parts A & B			
Self Only	$961.02	$1,545.63	N/A
Self + 1 dependent under 65	$1,578.70	$2,004.03	N/A
Self + 2 or more dependents under 65	$2,159.09	$2,548.78	N/A
Self + 1 dependent enrolled in Medicare Parts A & B	$1,556.75	$2,004.03	N/A
Self + 1 dependent enrolled in Medicare Parts A & B + 1 or more dependent(s) under 65	$2,159.09	$2,548.78	N/A
Retiree Over Age 65 and Enrolled in Medicare Part B Only			
Self Only	N/A	N/A	N/A
Self + 1 dependent under 65	N/A	N/A	N/A
Self + 2 or more dependents under 65	N/A	N/A	N/A
Self + 1 dependent enrolled in Medicare Parts A & B	N/A	N/A	N/A
Self + 1 dependent enrolled in Medicare Part B	N/A	N/A	N/A

[1] The rates are subject to the approval of the Board of Water and Power Commissioners.

[2] Effective July 1, 2018, the Medicare rates through UnitedHealthcare Medicare Advantage renew on a plan-year basis. As a result, those retirees enrolled in a Medicare tier will no longer receive a rate adjustment on January 1, 2019.

[3] Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan.

Rates for 2018-2019 Dental Plans

For LADWP-sponsored and IBEW Local 18-sponsored dental plans.

Coverage Level	United Concordia Preferred Dental Plan (PPO)	United Concordia Plus Dental Plan (DHMO)	Guardian Dental Plans (PPO and DHMO) (Local 18)[1]
Retiree only			
With Subsidy	$0.00	$0.00	$0.00
Without Subsidy	$35.79	$18.24	$117.90
Retiree +1 eligible dependent			
With Subsidy	$32.02	$9.13	$0.00
Without Subsidy	$67.81	$27.37	$117.90
Retiree +2 or more eligible dependents			
With Subsidy	$79.49	$18.74	$0.00
Without Subsidy	$115.28	$36.98	$117.90

[1]Retirees must be enrolled in an IBEW Local 18-sponsored dental plan prior to retirement to participate in the plan. If as a retiree you cancelled your IBEW Local 18-sponsored dental plan, you are now able to re-enroll into an IBEW Local 18-sponsored plan.

Close Eye on July

Take note that changes to plan premiums, and your retirement check deductions, take effect on June 30 for the month of July. This is different from cost-of-living adjustments to your retirement check, which are not reflected until July 31.

Retiree Health Plan Subsidy Chart

Rates are effective July 1, 2018 through June 30, 2019.[1]

Tier 2 retirees (employees who were hired on or after January 1, 2014) should call the LADWP Health Plans Administration Office at **(213) 367-2023** or **(800) 831-4778** for Tier 2 health and dental rates and subsidy information.

YEARS OF SERVICE	AGE AT RETIREMENT														
	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69
9 years or less	Minimum subsidy is $30.32														
10	$350.24	$356.60	$362.97	$369.34	$375.71	$382.08	$388.44	$394.81	$401.18	$407.55	$413.92	$420.28	$426.65	$433.02	$439.39
11	$420.28	$427.92	$435.57	$443.21	$450.85	$458.49	$466.13	$473.77	$481.42	$489.06	$496.70	$504.34	$511.98	$519.62	$527.26
12	$490.33	$499.25	$508.16	$517.08	$525.99	$534.91	$543.82	$552.74	$561.65	$570.57	$579.48	$588.40	$597.31	$606.23	$615.14
13	$560.38	$570.57	$580.75	$590.94	$601.13	$611.32	$621.51	$631.70	$641.89	$652.08	$662.26	$672.45	$682.64	$692.83	$703.02
14	$630.42	$641.89	$653.35	$664.81	$676.27	$687.74	$699.20	$710.66	$722.12	$733.59	$745.05	$756.51	$767.97	$779.43	$790.90
15	$700.47	$713.21	$725.94	$738.68	$751.42	$764.15	$776.89	$789.62	$802.36	$815.09	$827.83	$840.57	$853.30	$866.04	$878.77
16	$770.52	$784.53	$798.54	$812.55	$826.56	$840.57	$854.58	$868.59	$882.59	$896.60	$910.61	$924.62	$938.63	$952.64	$966.65
17	$840.57	$855.85	$871.13	$886.42	$901.70	$916.98	$932.26	$947.55	$962.83	$978.11	$993.40	$1,008.68	$1,023.96	$1,039.25	$1,054.53
18	$910.61	$927.17	$943.73	$960.28	$976.84	$993.40	$1,009.95	$1,026.51	$1,043.07	$1,059.62	$1,076.18	$1,092.74	$1,109.29	$1,125.85	$1,142.41
19	$980.66	$998.49	$1,016.32	$1,034.15	$1,051.98	$1,069.81	$1,087.64	$1,105.47	$1,123.30	$1,141.13	$1,158.96	$1,176.79	$1,194.62	$1,212.45	$1,230.28
20	$1,050.71	$1,069.81	$1,088.92	$1,108.02	$1,127.12	$1,146.23	$1,165.33	$1,184.43	$1,203.54	$1,222.64	$1,241.75	$1,260.85	$1,279.95	$1,299.06	$1,318.16
21	$1,120.76	$1,141.13	$1,161.51	$1,181.89	$1,202.26	$1,222.64	$1,243.02	$1,263.40	$1,283.77	$1,304.15	$1,324.53	$1,344.91	$1,365.28	$1,385.66	$1,406.04
22	$1,190.80	$1,212.45	$1,234.10	$1,255.76	$1,277.41	$1,299.06	$1,320.71	$1,342.36	$1,364.01	$1,385.66	$1,407.31	$1,428.96	$1,450.61	$1,472.26	$1,493.92
23	$1,260.85	$1,283.77	$1,306.70	$1,329.62	$1,352.55	$1,375.47	$1,398.40	$1,421.32	$1,444.25	$1,467.17	$1,490.09	$1,513.02	$1,535.94	$1,558.87	$1,581.79
24	$1,330.90	$1,355.09	$1,379.29	$1,403.49	$1,427.69	$1,451.89	$1,476.09	$1,500.28	$1,524.48	$1,548.68	$1,572.88	$1,597.08	$1,621.27	$1,645.47	$1,669.67
25	$1,400.94	$1,426.42	$1,451.89	$1,477.36	$1,502.83	$1,528.30	$1,553.77	$1,579.25	$1,604.72	$1,630.19	$1,655.66	$1,681.13	$1,706.60	$1,732.08	$1,751.18
26	$1,470.99	$1,497.74	$1,524.48	$1,551.23	$1,577.97	$1,604.72	$1,631.46	$1,658.21	$1,684.95	$1,711.70	$1,738.44	$1,751.18	$1,751.18	$1,751.18	
27	$1,541.04	$1,569.06	$1,597.08	$1,625.10	$1,653.11	$1,681.13	$1,709.15	$1,737.17	$1,751.18	$1,751.18	$1,751.18				
28	$1,611.09	$1,640.38	$1,669.67	$1,698.96	$1,728.26	$1,751.18	$1,751.18	$1,751.18							
29	$1,681.13	$1,711.70	$1,742.26	$1,751.18	$1,751.18										
30	$1,751.18	$1,751.18	$1,751.18												

There are additional rates that are not listed on this chart; contact the LADWP Health Plans Administration Office for those rates, if needed. The maximum subsidy is **$1,751.18**

[1] The rates are subject to the approval of the Board of Water and Power Commissioners.

Revised Mar 2018

Retiree Health Plan Subsidy Chart for Retired Employees Under Age 55

Rates are effective July 1, 2018 through June 30, 2019.

Years of Service	48	49	50	51	52	53	54
14 years or less	Minimum subsidy is $30.32						
15							
16							
17							$30.75
18			$30.84	$31.46	$32.08	$32.69	$33.31
19	$31.89	$32.56	$33.21	$33.88	$34.55	$35.21	$35.87
20	$34.17	$34.88	$35.59	$36.30	$37.01	$37.73	$38.44
21	$36.44	$37.21	$37.96	$38.72	$39.48	$40.24	$41.00
22	$38.72	$39.53	$40.33	$41.14	$41.95	$42.75	$43.56
23	$41.00	$41.85	$42.71	$43.56	$44.42	$45.27	$46.12
24	$43.28	$44.18	$45.08	$45.98	$46.89	$47.78	$48.69
25	$45.56	$46.51	$47.45	$48.40	$49.36	$50.30	$51.25
26	$47.83	$48.83	$49.83	$50.82	$51.82	$52.82	$53.81
27	$50.11	$51.16	$52.20	$53.24	$54.29	$55.33	$56.37
28	$52.39	$53.48	$54.57	$55.66	$56.76	$57.84	$58.94
29	$54.67	$55.81	$56.94	$58.08	$59.22	$60.36	$61.50
30	$56.94	$58.13	$59.31	$60.50	$61.69	$62.87	$64.06
31	$59.22	$60.46	$61.68	$62.92	$64.16	$65.39	$66.62
32	$61.50	$62.78	$64.06	$65.34	$66.62	$67.91	$69.19
33	$63.78	$65.11	$66.43	$67.76	$69.09	$70.42	
34	$66.06	$67.44	$68.80	$70.18			
35	$68.33	$69.76					
36	$70.61						

If years of service equal 37 or more, the maximum subsidy is **$71.81**.

Revised Mar 2018

Health Plan Comparison Charts

Benefits are coordinated with Medicare for retirees. For retirees with Medicare Parts A and B, see the health plan comparison charts on **pages 34-41**.

Medicare benefits will be considered primary for any eligible retiree (and/or covered spouse or domestic partner) who is age 65 or over.

LADWP-Sponsored UnitedHealthcare (UHC) Preferred Provider Organization (PPO) Options

For retirees under age 65 or with Medicare Part B only. Payments are based on UnitedHealthcare allowable amounts. Out-of-network charges are covered; co-pay and any amount in excess of the allowable amount are the member's responsibility for the non-PPO providers.

Retiree Under Age 65

Benefit Comparison	UHC PPO Plan A		UHC PPO Plan B		UHC PPO Plan C	
	PPO	Non-PPO*	PPO	Non-PPO*	PPO	Non-PPO*
Annual deductible	None	$200/ individual $400/family	$250/ individual $500/family	$500/ individual $1,000/ family	$2,000/individual $4,000/family	
Annual out-of-pocket maximum	$1,000/ individual $2,000/ family	$3,000/ individual $6,000/ family	$2,000/ individual $4,000/ family	$5,000/ individual $10,000/ family	$2,000/ individual $4,000/ family	$10,000/ individual $20,000/ family
Prescription Drugs (no deductible applies)						
Retail (up to a 31-day supply) Tier 1 Tier 2 Tier 3	Per prescription co-pay: $5 $10 $10		Per prescription co-pay: $10 $20 $20		Per prescription co-pay: $15 $30 $45	
Mail order (up to a 90-day supply) Tier 1 Tier 2 Tier 3	Per prescription co-pay: $10 $20 $20	Not covered	Per prescription co-pay: $20 $40 $40	Not covered	Per prescription co-pay: $30 $60 $90	Not covered
Hospital Services[1]						
Semi-private room and board	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Miscellaneous charges	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Ambulance services (scheduled ambulance services require prior authorization)	Covered at 90%	Covered at 90%	Covered at 90%	Covered at 90%	Covered at 80%	Covered at 80%

*Most non-network services other than office visits and prescription drugs require prior authorization. Check with UHC to determine which services are subject to the prior authorization requirement or benefits may be reduced.

[1]Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.

LADWP-Sponsored UnitedHealthcare (UHC) Preferred Provider Organization (PPO) Options, continued

Retiree Under Age 65

Benefit Comparison	UHC PPO Plan A		UHC PPO Plan B		UHC PPO Plan C	
	PPO	Non-PPO*	PPO	Non-PPO*	PPO	Non-PPO*
Physician Services						
Surgery – Outpatient	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Physician visits (office)	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%	Covered at 100%	Covered at 60%
Physical therapy (visit limitations apply)	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%	Covered at 100%	Covered at 60%
X-ray and lab services (provided in conjunction with a physician office visit)	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%
Accident/ emergency care [1,2]	$25 co-pay; co-pay waived if admitted directly to the hospital		$25 co-pay; co-pay waived if admitted directly to the hospital		$250 co-pay; co-pay waived if admitted directly to the hospital	
Preventive Health Services						
Preventive examination (no deductible)	Covered at 100%	Not covered	Covered at 100%	Not covered	Covered at 100%	Not covered
Vision/hearing exam	$10 co-pay; one exam every two years	Not covered	$10 co-pay; one exam every two years	Not covered	Covered at 100%; one exam every two years	Not covered
Well-baby care	Covered at 100%	Not covered	Covered at 100%	Not covered	Covered at 100%	Not covered

*Most non-network services other than office visits and prescription drugs require prior authorization. Check with UHC to determine which services are subject to the prior authorization requirement or benefits may be reduced.

[1] If ER services do not result in direct admission, the calendar-year deductible does not apply.

[2] An emergency is a serious medical condition or symptom resulting from a health condition that arises suddenly and in the judgment of a reasonable person requires immediate treatment, generally received within 24 hours of onset to avoid jeopardy to life or health. Claims that do not meet this criterion will be denied.

Pre-65 exclusive details

LADWP-Sponsored UnitedHealthcare (UHC) Preferred Provider Organization (PPO) Options, continued

Retiree Under Age 65

Benefit Comparison	UHC PPO Plan A		UHC PPO Plan B		UHC PPO Plan C	
	PPO	Non-PPO*	PPO	Non-PPO*	PPO	Non-PPO*
Mental Health Care and Alcohol/Substance Abuse[1]						
Outpatient	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%	Covered at 100%	Covered at 60%
Inpatient (non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit or not at all)	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Durable medical equipment/orthotics	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
	Limited to single purchase of a type of DME every three years, except for orthotics; other restrictions apply					
Prosthetics	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Skilled nursing (custodial care is not covered)	Covered at 90%; up to 60 days/ calendar year	Covered at 60%; up to 60 days/ calendar year	Covered at 90%; up to 60 days/ calendar year	Covered at 60%; up to 60 days/ calendar year	Covered at 80%; up to 60 days per calendar year	Covered at 80% up to 60 days/ calendar year
Home health care/ home infusion care	Covered at 90%; maximum of 100 visits/ year	Covered at 60%; maximum of 100 visits/ year	Covered at 90%; maximum of 100 visits/ year	Covered at 60%; maximum of 100 visits/ year	Covered at 80% ; maximum of 100 visits/ year	Covered at 60%; maximum of 100 visits/ year
Hospice care	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%
Manipulative treatments (chiropractor)	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%	Covered at 100%	Covered at 60%
	24 visits		20 visits		20 visits	

*Most non-network services other than office visits and prescription drugs require prior authorization. Check with UHC to determine which services are subject to the prior authorization requirement or benefits may be reduced.

[1] Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the United Behavioral Health (UBH) Participating Providers and Non-Participating Providers. Inpatient services for medical acute detoxification are accessed through UniteHealthcare.

Pre-65 exclusive details

LADWP-Sponsored Health Maintenance Organization (HMO) Options

Enrollees must reside within the HMO's service area.

Retiree Under Age 65

Benefit Comparison	Kaiser For retirees under age 65	UHC HMO For retirees under age 65 or with Medicare Part B only	Health Plan of Nevada (HPN) For retirees under age 65 or with Medicare Part B only
Annual out-of-pocket maximum	$1,500/individual $1,500/individual in Family $3,000/family	$800/individual $2,400/family	N/A
Physician and hospital	Kaiser Permanente physicians and hospitals	> Physicians who are members of the plan's network > Any licensed acute care general hospital designated by a plan physician	> HPN physicians > Any licensed acute care general hospital designated by an HPN physician
Hospital	> Semi-private room and board, prescription drugs and associated expenses covered at 100% > Ambulance, if authorized, covered at 100%	> Semi-private room and board, prescription drugs and associated expenses covered at 100% > Ambulance services, as medically necessary, covered at 100%	> Semi-private room and board, prescription drugs and associated expenses covered at 100% > Ambulance: $50 per trip when medically necessary
Surgical	$5 co-pay/procedure, including assistant surgeon and anesthesiologist	Covered at 100%, including assistant surgeon and anesthesiologist	Covered at 100% including assistant surgeon
Doctor visits	> In-hospital: covered at 100% > Out-of-hospital: $5 co-pay per visit[1]	> In-hospital: covered at 100% > Out-of-hospital: $3 co-pay per visit	> In-hospital: covered at 100% > Out-of-hospital: $3 co-pay per visit[1]
Physical therapy	> Inpatient: covered at 100% > Outpatient: $5 per office visit	> Inpatient: covered at 100% > Outpatient: $3 per office visit	> Inpatient: covered at 100% > Outpatient: $3 per office visit
X-ray and lab services	Covered at 100%	Covered at 100%	Covered at 100%

[1] $20 charge per house call when medically necessary.

Pre-65 exclusive details

LADWP-Sponsored Health Maintenance Organization (HMO) Options, continued

Retiree Under Age 65

Benefit Comparison	Kaiser For retirees under age 65	UHC HMO For retirees under age 65 or with Medicare Part B only	Health Plan of Nevada (HPN) For retirees under age 65 or with Medicare Part B only
Prescription drugs (only FDA-approved drugs are covered)	$5 per prescription for up to 100-day supply[1,2]	> Retail: $5 co-pay per 30-day supply from UHC formulary at participating pharmacies > Mail order: $5 co-pay for up to 90-day supply of maintenance medications	**Retail** > Generic: $7 co-pay for drugs in preferred drug list > Brand-name in preferred drug list when no generic available: $15 co-pay > Brand-name in preferred drug list when generic available: $15 co-pay plus difference between generic and brand-name > Preferred brand-name when no generic available: $40 co-pay > Brand-name when generic available: $40 co-pay plus difference between generic and brand-name **Mail order** (up to 90-day supply): > Generic: $14 co-pay > Brand-name: $30 co-pay
Extended care or skilled nursing facility	Covered at 100% for up to 100 days per benefit period. **Custodial care is not covered.**	Covered at 100% for up to 100 consecutive days from the first treatment per disability. **Custodial care is not covered.**	Covered at 100% for up to 100 days when prescribed by an HPN physician. **Custodial care is not covered.**
Maternity	> Prenatal and postnatal care office visits: covered at 100% > Hospital services, physician services, and delivery and newborn care: covered at 100%	> Prenatal and postnatal care office visits: covered at 100% > Hospital services, physician services, and delivery and newborn care: covered at 100%	> Semi-private room and board, prescription drugs and associated expenses covered at 100%
Durable medical equipment (DME)	Covered at 100% if medically necessary and doctor prescribes	Covered at 100% if medically necessary and doctor prescribes	$100 or 50% of DME purchase or rental price, whichever is less
Mental health care	> In-hospital: covered at 100% > Out-of-hospital: $5 co-pay per visit	> In-hospital: covered at 100% > Out-of-hospital: $3 co-pay per visit	> In-hospital: covered at 100% > Out-of-hospital: $3 co-pay per visit

[1] Only prescribed drugs listed in the formulary will be covered, unless requested by physician.
[2] Sexual dysfunction drugs covered at 50% coinsurance with a maximum dosage limit of 27 doses for 100 day supply.

Pre-65 exclusive details

Retiree Under Age 65

Benefit Comparison	Kaiser For retirees under age 65	UHC HMO For retirees under age 65 or with Medicare Part B only	Health Plan of Nevada (HPN) For retirees under age 65 or with Medicare Part B only
Eye examinations	$5 co-pay per visit	$3 co-pay per visit	Provided only as part of an examination to diagnose an illness or injury to the eye
Emergency care	> $5 co-pay at Kaiser Permanente facilities (waived if admitted) > $5 co-pay at non-plan facilities (waived if admitted); limited to life-threatening emergencies or where choice of facility is beyond the control of you or your immediate family[1]	$35 co-pay per emergency room visit; waived if admitted as an inpatient	> $25 co-pay for physician services > $75 co-pay per ER visit (waived if admitted) > No charge for inpatient hospital services
Urgent Care	$5 co-pay per visit	> $3 co-pay per visit in service area > $35 co-pay per visit outside service area	$15 co-pay per visit
Home health care	Covered at 100% up to 100 visits per year	Covered at 100% up to 100 visits per year	> Covered at 100% if home confined; includes private-duty nursing and home care service > $20 co-pay for physician house calls
Hospice care	Covered at 100%; prognosis of life expectancy of six months or less	Covered at 100%; prognosis of life expectancy of one year or less	> Covered at 100% > Inpatient respite services: Limited to $1,500 per member/calendar year at no charge > Outpatient respite services: Limited to $1,000 per member/calendar year at no charge > Bereavement services: $20 co-pay per visit; limited to five group therapy sessions or $500, whichever is less

[1] Outside service area, member must notify Kaiser within 24 hours of emergency.

Pre-65 exclusive details

LADWP-Sponsored UnitedHealthcare (UHC) Preferred Provider Organization (PPO) Options

For retirees with Medicare Parts A and B. Payments are based on UnitedHealthcare allowable amounts. Out-of-network charges covered; co-pay and any amount in excess of the allowable amount are the member's responsibility for the non-PPO providers.

Retiree Over Age 65

Benefit Comparison	UHC PPO Plan A		UHC PPO Plan B		UHC PPO Plan C	
	PPO	**Non-PPO***	**PPO**	**Non-PPO***	**PPO**	**Non-PPO***
Annual deductible	None	$200/ individual $400/family	$250/ individual $500/family	$500/ individual $1,000/ family	$2,000/individual $4,000/family	
Annual out-of-pocket maximum	$1,000/ individual $2,000/ family	$3,000/ individual $6,000/ family	$2,000/ individual $4,000/ family	$5,000/ individual $10,000/ family	$2,000/ individual $4,000/ family	$10,000/ individual $20,000/ family
Prescription Drugs (no deductible applies) (Benefits listed are for the Initial and Gap stages as defined by Medicare; different benefits apply during the Catastrophic stage)						
Retail (30-day supply) Tier 1 Tier 2 Tier 3	Per prescription co-pay: $5 $10 $10	Not covered	Per prescription co-pay: $10 $20 $20	Not covered	Per prescription co-pay: $10 $30 Covered at 50% up to $95	Not covered
Mail order (90-day supply) Tier 1 Tier 2 Tier 3	Per prescription co-pay: $10 $20 $20	Not covered	Per prescription co-pay: $20 $40 $40	Not covered	Per prescription co-pay: $20 $60 Covered at 50% up to $190	Not covered
Hospital Services[1]						
Semi-private room and board	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Miscellaneous charges	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Ambulance services (scheduled ambulance services require pre-authorization)	Covered at 90%	Covered at 90%	Covered at 90%	Covered at 90%	Covered at 80%	Covered at 80%

* Most non-network services other than office visits and prescription drugs require prior authorization. Check with UHC to determine which services are subject to the prior authorization requirement or benefits may be reduced.

[1] Hospital-based physicians (e.g., anesthesiologists, radiologists, pathologists, etc..) at a PPO hospital may not be in the PPO network. In order to assure PPO benefits for eligible physician charges, confirm that the physicians attending you while you are in the hospital are part of the PPO network.

Retiree Over Age 65

Benefit Comparison	UHC PPO Plan A		UHC PPO Plan B		UHC PPO Plan C	
	PPO	Non-PPO*	PPO	Non-PPO*	PPO	Non-PPO*
Physician Services						
Surgery – Outpatient	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Physician visits (office)	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%
Physical therapy (limits apply)	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%
X-ray and lab services – routine (some services may require preauthorization by UHC)	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%
Accident/ emergency care[1,2] (no deductible)	$25 co-pay; co-pay waived if admitted directly to the hospital		$25 co-pay; co-pay waived if admitted directly to the hospital		$250 co-pay; co-pay waived if admitted directly to the hospital	
Preventive Health Services						
Preventive examination (no deductible)	Covered at 100%	Not covered	Covered at 100%	Not covered	Covered at 100%	Not covered
Vision/hearing exam	Covered at 100%; one exam every two years	Not covered	Covered at 100%; one exam every two years	Not covered	Covered at 100%; one exam every two years	Not covered
Well-baby care	Covered at 100%	Not covered	Covered at 100%	Not covered	Covered at 100%	Not covered

* Most non-network services other than office visits and prescription drug require prior authorization. Check with UHC to determine which services are subject to the prior authorization requirement or benefits may be reduced.

[1] If ER services do not result in direct admission, the calendar -year deductible does not apply.

[2] An emergency is a serious medical condition or symptom resulting from a health condition that arises suddenly and in the judgment of a reasonable person requires immediate treatment, generally received within 24 hours of onset to avoid jeopardy to life or health. Claims that do not meet this criterion will be denied.

Post-65 exclusive details

LADWP-Sponsored UnitedHealthcare (UHC) Preferred Provider Organization (PPO) Options, continued

Retiree Over Age 65

Benefit Comparison	UHC PPO Plan A		UHC PPO Plan B		UHC PPO Plan C	
	PPO	Non-PPO*	PPO	Non-PPO*	PPO	Non-PPO*
Mental Health Care and Alcohol/Substance Abuse[1]						
Outpatient	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%
Inpatient (non-emergency inpatient mental health requires preauthorization or else subject to the plan paying only 50% of the benefit of not at all)	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Durable medical equipment/orthotics	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%; pre-service notification required for equipment over $1,000
	Limited to single purchase of a type of DME every three years, except for orthotics; other restrictions apply					
Prosthetics	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Skilled nursing (custodial care is not covered)	Covered at 90%; up to 60 days/ calendar year	Covered at 60%; up to 60 days/ calendar year	Covered at 90%; up to 60 days/ calendar year	Covered at 60%; up to 60 days/ calendar year	Covered at 80%; up to 60 days/ calendar year	Covered at 20% up to 60 days/ calendar year
Home health care/ home infusion care (maximum 100 visits per year)	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Hospice care	Covered at 90%	Covered at 60%	Covered at 90%	Covered at 60%	Covered at 80%	Covered at 60%
Acupuncture services (20 treatments per year)	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%	$10 co-pay	Covered at 60%
Manipulative treatments (chiropractor)	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 60%
	24 visits		20 visits		20 visits	

* Most non-network services other than office visits and prescription drug require prior authorization. Check with UHC to determine which services are subject to the prior authorization requirement or benefits may be reduced.

[1] Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the United Behavioral Health (UBH) Participating Providers and Non-Participating Providers. Inpatient services for medical acute detoxification are accessed through UnitedHealthcare.

Post-65 exclusive details

LADWP-Sponsored Health Maintenance Organization (HMO) Options

Enrollees must reside within the HMO's service area.

Retiree Over Age 65

Benefit Comparison	Kaiser Senior Advantage For retirees with Medicare Parts A and B or Medicare Part B only	UHC HMO Senior Advantage For retirees with Medicare Parts A and B	Health Plan of Nevada (HPN) For retirees with Medicare Parts A and B	
			In-Network	Out-of-Network
Annual out-of-pocket maximum	$1,500/individual $1,500/individual in Family $3,000/family	$6,700/individual	$1,500/individual	$10,000/individual
Physician and hospital	Kaiser Permanente physicians and hospitals	> Physicians who are members of the plan's network > Any licenses acute care general hospital designated by a plan physician	> HPN physicians > Any licensed acute care general hospital designated by an HPN physician	Provided or prescribed by a duly licensed provider
Hospital	> Semi-private room and board, prescription drugs and associated expenses covered at 100% > Ambulance, if authorized, covered at 100%	> Inpatient Hospital Stay covered at 100% > Ambulance, as medically necessary, covered at 100%	> Semi-private room and board, prescription drugs and associated expenses covered at 100% > Ambulance, if authorized, covered at 100%	> Semi-private room and board, prescription drugs and associated expenses: $750 copay per admission > Ambulance, if authorized, covered at 80%"
Surgical	$5 co-pay per procedure, including assistant surgeon and anesthesiologist	Covered at 100%	Covered at 100%	Covered at 80%
Doctor Visits	> In-hospital: covered at 100% > Out-of-hospital: $5 co-pay per visit[1]	Covered at 100%	> In-hospital: covered at 100% > Out-of-hospital: $3 co-pay per visit[3] > Specialist: $10 co-pay per visit	> In-hospital: $750 copay > Out-of-hospital: $35 co-pay per visit[3] > Specialist: $35 co-pay per visit
Physical therapy	> Inpatient: covered at 100% > Outpatient: $5 per office visit[2]	Covered at 100%	Outpatient: $10 co-pay per office visit	Outpatient: $35 co-pay per office visit
X-ray and lab services	Covered at 100%	Covered at 100%	> Lab services: 0% to 50% of the cost > Outpatient X-rays: Covered at 100%	> Lab services: 20% to 50% of the cost > Outpatient X-rays: Covered at 80%
Prescription drugs (only FDA-approved drugs are covered) (Benefits listed are for the Initial and Gap stages as defined by Medicare; different benefits apply during the Catastrophic stage)	$5 per prescription for up to 100-day supply[4,5]	> Retail: $5 co-pay per 30-day supply from UHC formulary at participating pharmacies > Mail order: $5 co-pay for up to 90-day supply of maintenance medications	Retail and mail order: > Tier 1: Preferred generic drugs in formulary: $5 co-pay > Tier 2: Preferred brand-name in formulary: $15 co-pay > Tier 3: Non-preferred brand-name: $30 co-pay"	

[1] Home visits covered at 100% when part of a prescribed home care program.
[2] Limited to short-term therapy.
[3] $20 charge per house call when medically necessary
[4] Only prescribed drugs listed in the formulary will be covered, unless requested by physician.
[5] Sexual dysfunction drugs covered at 50% coinsurance with a maximum dosage limit of 27 doses for 100-day supply.

Post-65 exclusive details

LADWP-Sponsored Health Maintenance Organization (HMO) Options, continued

Retiree Over Age 65

Benefit Comparison	Kaiser Senior Advantage For retirees with Medicare Parts A and B or Medicare Part B only	UHC HMO Senior Advantage For retirees with Medicare Parts A and B	Health Plan of Nevada (HPN) For retirees with Medicare Parts A and B	
			In-Network	Out-of-Network
Extended care or skilled nursing facility	Covered at 100% for up to 100 days per benefit period. **Custodial care is not covered.**	Covered at 100% for up to 100 consecutive days from the first treatment per disability. **Custodial care is not covered.**	Covered at 100% for up to 100 days when prescribed by an HPN physician.	Covered at 80% for up to 100 days when prescribed by an HPN physician.
			Custodial care is not covered	
Maternity	> Prenatal and postnatal care office visits: covered at 100% > Hospital services, physician services, and delivery and newborn care: covered at 100%	> Prenatal and postnatal care office visits: covered at 100% > Hospital services, physician services, and delivery and newborn care: covered at 100%	Semi-private room and board, prescription drugs and associated expenses covered at 100%	Semi-private room and board, prescription drugs and associated expenses: $750 copay per admission
Durable medical equipment (DME)	Covered at 100% if medically necessary and doctor prescribes	Covered at 100% if medically necessary and doctor prescribes	Covered at 100%	Covered at 80%
Mental Health care	> Inpatient: Covered at 100% > Outpatient: $5 co-pay per visit	Covered at 100%	> Inpatient: Covered at 100% up to 190 days > Outpatient: $10 co-pay per visit	> Inpatient: $750 co-pay; Care in a psychiatric hospital covered up to 190 days/lifetime > Outpatient: $35 co-pay/visit
Eye examinations	$5 co-pay per visit	Covered at 100%	> $3 co-pay for vision exam once every calendar year. > Glasses or Contact lenses after cataract surgery: Covered at 80% > Frames, Lenses, and Contact Lenses: Up to $60 combined allowance every 24 months	> $35 co-pay for vision exam once every calendar year. > Glasses or Contact lenses after cataract surgery: Covered at 80% > Frames, Lenses, and Contact Lenses: Not covered
Hearing aids	> Hearing exams: $5 co-pay per visit > Hearing aids: up to $500 allowance per device per ear every 36 months	$500 allowance per year	> Hearing exams: $3 co-pay per visit > Hearing aids: $330 copay for each Behind-the-Ear hearing aid. $380 copay for each Open-Fit-in-the-Canal hearing aid. Limited to 2 hearing aids/devices per year.	> Hearing exams to diagnose and treat hearing and balance issues: $35 co-pay per visit > Hearing aids: Not Covered
Emergency care	> $5 co-pay at Kaiser Permanente facilities (waived if admitted) > $5 co-pay at non-plan facilities (waived if admitted); limited to life-threatening emergencies or where choice of facility is beyond the control of you or your immediate family[1]	Covered at 100%	$25 co-pay per emergency room visit; waived if admitted as an inpatient	
Urgent Care	$5 co-pay per visit	Covered at 100%	$15 co-pay per visit	$25 co-pay per visit
Home health care	Covered at 100% up to 100 visits per year	Covered at 100% (no limit)	Covered at 100%[2]	Covered at 80%[2]
Hospice care	Covered at 100%; prognosis of life expectancy of six months or less	Covered by Original Medicare	Covered by Medicare; not an HPN benefit	

[1] Outside service area, member must notify Kaiser within 24 hours of emergency.
[2] $20 charge per house call when medically necessary

Post-65 exclusive details

IBEW Local 18-Sponsored Plan Options

Anthem Blue Cross HMO and PPO

(For current IBEW Local 18 Retirees Only) – For retirees under age 65 and for retirees over age 65 with Medicare Parts A and B. Retirees must be enrolled in Anthem Blue Cross or Guardian Dental prior to retirement to participate in the plan. If as a retiree you cancelled your IBEW Local 18-sponsored medical plan, you are now able to re-enroll into an IBEW Local 18-sponsored plan.

Retiree Under & Over Age 65

Benefit Comparison	Anthem Blue Cross HMO	Anthem Blue Cross PPO	
		In-Network	Out-of-Network[1]
Calendar-year deductible	N/A	$250/individual; maximum of three separate deductibles/family	$1,000/individual; maximum of three separate deductibles/family
Annual out-of-pocket maximum[2]	$500/individual $1,000/two-party $1,500/family	$2,000/individual $4,000/family	$6,000/individual $12,000/family
Lifetime maximum	N/A	N/A	
Choice of physician	Physicians who are members of the plan's network	Any licensed physician	
Choice of hospital	Any licensed acute care general hospital selected and designated by a plan physician	Any licensed acute care general hospital	
Physician Services			
In-hospital	No co-pay	Covered at 80%	Covered at 60%[3]
Physician office visits	No co-pay includes LiveHealth Online visits	No co-pay; deductible waived; includes LiveHealth Online visits	Covered at 60%
Specialist office visits	No co-pay	$35 co-pay/visit; deductible waived	Covered at 60%
Hospital Services			
Inpatient and outpatient care	No co-pay	Covered at 80%	Covered at 60%[3]
Ambulance	No co-pay	Covered at 70%	Covered at 70%

1 When using out-of-network providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible and percentage co-pay.

2 The annual out-of-pocket maximum is the most you pay in a calendar year for covered medical expenses and prescription co-pays. For the PPO out-of-network, you are responsible for costs in excess of the maximum allowed amount.

3 For PPO out-of-network, $500/admission deductible applies for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained; waived for emergency admission.

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains covered services, as well as any inclusions and limitations.

Pre-65 exclusive details

Post-65 exclusive details

IBEW Local 18-Sponsored Anthem Blue Cross HMO and PPO Plan Options, continued

Retiree Under & Over Age 65

Benefit Comparison	Anthem Blue Cross HMO	Anthem Blue Cross PPO	
		In-Network	Out-of-Network[1]
Preventive care	No co-pay	No co-pay; deductible waived	Covered at 60%
Surgery – Outpatient	No co-pay	Covered at 80%	Covered at 60%
Nurse - Home health care (limited to 100 visits per calendar year; one visit by a home health aide equals four hours or less)	No co-pay	Covered at 80%	Covered at 60%
Physical therapy (includes physical medicine, occupational therapy)	No co-pay; limited to a 60-day period of care	Covered at 80%	Covered at 60%
Chiropractic care	$10 co-pay/office visit; 30 visits per calendar year; visits combined with acupuncture	No co-pay; deductible waived	Covered at 60%
		Limited to 30 visits/calendar year	
Acupuncture (services for the treatment of disease, illness or injury)	$10 co-pay/office visit; 30 visits per calendar year; visits combined with chiropractic care	No co-pay; deductible waived	Covered at 60%
		Limited to 20 visits/calendar year	
X-ray and lab	No co-pay	Covered at 80%	Covered at 60%
Extended care/skilled nursing facility	No co-pay	Covered at 80%	Covered at 60%
	Limited to 100 days calendar/year (does not apply for Mental Health and Substance Abuse)		

[1] When using out-of-network providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible and percentage co-pay.

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains covered services, as well as any inclusions and limitations.

Pre-65 exclusive details **Post-65 exclusive details**

Retiree Under & Over Age 65

Benefit Comparison	Anthem Blue Cross HMO	Anthem Blue Cross PPO	
		In-Network	Out-of-Network[1]
Prescription Drugs			
Retail (30-day supply)	Generic: $5 co-pay Brand-name: $10 co-pay	Generic: $5 co-pay Brand-name: $10 co-pay	Generic: $5 co-pay Brand-name: $10 co-pay plus 50% of the remaining drug maximum allowed amount, plus all costs in excess of the allowed amount
Mail order (90-day supply)	Generic: $10 co-pay Brand-name: $20 co-pay	Generic: $10 co-pay Brand-name: $20 co-pay	N/A
Maternity			
Physician office visits	No co-pay	No co-pay; deductible waived	Covered at 60%
Specialist office visits	No co-pay	$35 co-pay; deductible waived	Covered at 60%
Hospital services	No co-pay	Covered at 80%	Covered at 60%
Mental or Nervous Disorders and Substance Abuse			
Outpatient	No co-pay	No co-pay; deductible waived	Covered at 60%
Inpatient	No co-pay	Covered at 80%	Covered at 60%
Emergency care	No co-pay	Covered at 80% $100 deductible; waived if admitted	Covered at 80%
Urgent care	No co-pay	$25 co-pay/visit; deductible waived	Covered at 60%
Body scan	One body scan, which includes a cervical spine scan, for retiree and spouse/domestic partner, every plan year, at any licensed body scan provider; $1,000 maximum payable per scan[2]		

[1] When using out-of-network providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible and percentage co-pay.
[2] Body scan available to retirees and spouse/domestic partner under age 65.

	Anthem Blue Cross HMO	Anthem Blue Cross PPO
Vision Care[1]	**Services provided through Vision Service Plan (VSP) for those enrolled in either the Anthem Blue Cross HMO or PPO**	
	In-Network	**Out-of-network (VSP covers)**
Exam	No co-pay; every 12 months	Up to $50
Lenses	No co-pay; every 12 months	Single: up to $50, Bifocal: up to $75 Trifocal: up to $100
Frames	No co-pay; every 12 months; $130 plan allowance	Up to $70
Contact lenses (in lieu of glasses)	$120 allowance	Up to $120

[1] Services provided through Vision Service Plan (VSP). See plan limitations and exclusions for full disclosure.

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Summary of Benefits, which explains covered services, as well as any inclusions and limitations.

Dental Plan Comparison Charts

LADWP-Sponsored Dental Plan Options

Benefit Comparison	United Concordia Preferred Alliance Network A Fee-for-Services/Preferred Provider Organization (PPO)		United Concordia Plus Dental Health Maintenance Organization (DHMO)
	In-Network	Out-of-Network	
Choice of dentist	United Concordia Alliance (PPO) dentists only	Any licensed dentist or specialist	United Concordia Plus DHMO panel dentists only
Annual deductible	$25/person; $75/family	$25/person; $75/family	None
Annual benefit maximum	$1,500 per calendar year	$1,500 per calendar year	Unlimited
Covered Services			
Diagnostic and preventive (no deductible; includes exams, X-rays, routine cleaning, fluoride treatments, sealants)	Covered at 100% of PPO-approved fee	Covered at 100% of the United Concordia allowable charge	Covered at 100%
Basic services (basic restorative, oral surgery, endodontics, repairs, simple extractions)	Covered at 80% of PPO-approved fee	Covered at 80% of the United Concordia allowable charge	Co-pay according to fee schedule
Major services (crowns, inlays, onlays, prosthetics)	Covered at 70% of PPO-approved fee	Covered at 50% of the United Concordia allowable charge	Co-pay according to fee schedule (impacted extractions only)
Orthodontics (diagnostic, active retention treatment)	Not covered	Not covered	Children: $1,500 co-pay Adults: $2,000 co-pay Covers banding and retention only
Limitations			
Oral exams	Two per 12 months		One per six consecutive months
Teeth Cleaning	Two per 12 months. One additional during pregnancy under the care of a physician.		One per six consecutive months
Bitewing X-rays	One set per 12 months for individuals age 14 and over; one set per 6 months for children under age 14		One per six consecutive months
Fluoride treatments	Two per 12 months to age 19		Two per six consecutive months to age 19
Full mouth X-rays	Once in a five-year period		One set every three years
Inlays/crowns/bridges/ dentures	Once in a five-year period		No limit
Emergency services	Standard plan coverage, to annual maximum		Subject to members copayment schedule at member's dentist; $100 maximum benefit for more than 50 miles away from primary office

IBEW Local 18-Sponsored Dental Plan Options

FOR CURRENT IBEW LOCAL 18 RETIREES ONLY. (If, as a retiree, you cancelled your IBEW Local 18-sponsored dental plan, you are now able to re-enroll into a Local 18-sponsored plan.)

Benefit Comparison	Preferred Provider Organization (PPO) Plan		DHMO A Prepaid/Managed Dental Care Plan
	In-Network	Out-of-Network	
Choice of dentist	Any PPO provider in the DentalGuard Preferred network	Any licensed dentist	Any Guardian DHMO dentist
Annual deductible	None	$25 per person; $75 per family (waived for diagnostic and preventive services)	None
Annual maximum	$2,000/individual; excluding orthodontia (in-network and out-of-network combined)	$2,000/individual; excluding orthodontia (in-network and out-of-network combined)	Unlimited
Covered Services			
Diagnostic and preventive (no deductible; oral examinations, X-rays, biopsy/tissue, routine cleaning, fluoride treatments)	100% of PPO fee	100% of customary and reasonable charges; deductible does not apply	100% after co-pay
Basic services (basic restorative, oral surgery, including extractions, fillings, root canals, periodontic (gum) treatment, sealants; endodontics, repairs)	90% of PPO fee	80% of customary and reasonable charges	Covered at 100%; co-pay required for sealants; one sealant per tooth in any three-year period to age 16 on permanent teeth Periodontics: Scaling and root planing limited to one course of therapy per quadrant during any 12-month period
Major services (crowns, inlays, onlays, prosthetics)	60% of PPO fee	60% of customary and reasonable charges	100% after co-pay
Orthodontics	For adults and children 80% of PPO rate; subject to $2,000 lifetime maximum per person (in-network and out-of-network combined)	For adults and children; 80% of customary and reasonable; subject to $2,000 lifetime maximum/person (in-network and out-of-network combined)	Children: $1,500 co-pay Adults: $2,800 co-pay

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

IBEW Local 18-Sponsored Dental Plan Options

Benefit Comparison	Preferred Provider Organization (PPO) Plan		DHMO A Prepaid/Managed Dental Care Plan
	In-Network	Out-of-Network	
Limitations			
Oral exams	Two per calendar year		Two per calendar year
Teeth Cleaning	Two per calendar year		Two per calendar year
Bitewing X-rays	Two sets every 12 months		No limit
Fluoride treatments	Two per calendar year; to age 19		Two every 12 months
Full-mouth X-rays	One set every three years		One set every three years
Inlays/crowns/bridges/ dentures	Once in a five-year period		Once in a five-year period
Emergency services	Standard plan coverage, to annual maximum		No charge for member's dentist; limited to $50 benefit for providers other than member's dentist

Please note: This is a summary only. For more detailed information about the benefits, please refer to the Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations in your plan.

Wellness and Program Resources

As a retiree, when you actively engage in healthy behaviors, you can live a longer, higher-quality life. LADWP is committed to providing resources that will help you and your covered family members meet your wellness goals. You and your family members enrolled in LADWP or IBEW Local 18-sponsored health plans can participate in the following wellness activities offered through our health plan providers:

REGENERATE
Your Health | Your Life
Los Angeles Department of Water & Power

LADWP-Sponsored Health Plans

Kaiser Permanente

For more information on Kaiser resources, visit ***www.kp.org***

NEW! Telephone Visits

You can now get care from a doctor by phone for some minor health conditions that do not require an in-person medical exam. You must be 18 years of age or over and have had at least one prior face-to-face visit with a Kaiser doctor. Contact Kaiser for more information.

My Health Manager

Schedule doctor appointments, refill prescriptions or other health-related items online.

Healthy lifestyle programs

Online resources to help you stay active, quit smoking, lose weight or eat better.

Good health on the go

An app to help you create a daily walking routine.

Wellness coaches

To give you extra support when you make healthy changes.

Farmers market

Purchase fresh fruits and veggies at Kaiser facilities, or schedule delivery to your home.

Complimentary health

Support your health with complimentary care. Find an acupuncturist, chiropractor, or massage therapist. Also, Join Active&Fit – and get moving by going to ***www.kp.org/choosehealthy.***

NEW Silver&Fit (Must be a Kaiser Permanente Senior Advantage member and have Medicare Part B assigned to Kaiser Permanente)

Kaiser Permanente Senior Advantage Medicare health plan members get free gym membership at participating gyms- or home fitness kits. The Silver&Fit program can help you stay fit and thrive. To choose a gym, visit ***www.silverandfit.com.***

UnitedHealthcare (UHC)

For more information on UHC resources, visit ***MyUHC.com*** (for UHC PPO and HMO)

Connecting all your benefit, health and wellness information on one site

- Experience innovative health and wellness tools
- Search for a doctor, clinic, hospital or lab
- See the current status of your claims, as well as claim history
- Get tips on living healthy and using health plan benefits to your advantage
- Get reminders when it's time for checkups, prescription refills or treatments

- Get suggestions on when to get immunizations, well-visits, routine tests or lab work
- Chat with a nurse

SilverSneakers® Fitness Program (for UHC Medicare Advantage HMO Plan with Medicare Parts A and B)

Available at no cost to help our retirees stay physically fit and active. Includes basic fitness membership, tools for home fitness (if covered gym is over 15 miles away). Learn more at ***www.silversneakers.com***.

Virtual Visits (for UHC PPO)

Talk with a doctor from your laptop or mobile device, a convenient and affordable way to access care. Covered under your UHC PPO health plan benefits, and coming soon to UHC HMO. Learn more on ***www.myUHC.com*** or UHC's Health4Me® app.

Real Appeal Weight Loss Program
(for UHC PPO and coming soon to UHC HMO)

This program includes a personalized transformation coach for one year, 24/7 online support and mobile app, a "success kit" and more

UHC NurseLine Services (for UHC PPO, HMO, and MedicareAdvantage HMO)

Coping with health concerns can be time-consuming and complex. With so many choices, it can be hard to know where to look for information and support. NurseLine was designed specifically to help make your health decisions simple and convenient by providing:

- Immediate answers to your health questions anytime, anywhere – 24 hours a day, 7 days a week.
- Access to registered nurses with clinical experience.
- Information to guide your health care decisions.

To talk with a NurseLine nurse, call the member number on your health plan ID card.

Introducing Rally (for UHC PPO and HMO)

An app offered by UnitedHealthcare that makes it easier for you to improve and maintain your health. Based on your responses to a quick Health Survey, you'll get your Rally Age, a measure of your overall health. Once you learn your Rally Age, you'll get personalized recommendations, known as Missions, designed to help you start improving your diet, fitness, and mood. Register today at ***myuhc.com.***

UnitedHealth Allies Health Discount Program
(for PPO and HMO)

We want to help you and your family live healthier lives. Our health discount program is designed to save you money – typically 10 percent to 50 percent – on health and wellness products and services beyond what's included in your benefit plan. Visit a participating provider and save on:

- Laser eye surgery.
- Acupuncture, chiropractic care and massage therapy.
- Assisted living and respite programs.
- Infertility support services.
- Weight management programs.
- Nutrition counseling.
- Fitness clubs including Anytime Fitness, Curves, Gold's Gym, Jazzercise, MyGym and Snap Fitness
- Smoking cessation.

Go to ***myhc.com*** and click on either the Health & Wellness tab and Discounts or the Health Resource tab and UnitedHealth Allies.

Solutions For Caregivers (for UHC Medicare Advantage HMO)

At no additional cost, UHC can help support you if you care for others. This program provides:

- Access to a Professional Care Manager
- On-site Assessments
- Personalized Care Plans
- Coordination of Services
- If you or someone you know needs support, call us at 1-866-896-1895, 24 hours a day, 7 days a week.

Health Plan of Nevada (HPN)

Virtual Visits through NowClinic

Talk with a doctor from your computer or mobile device, a convenient and affordable way to access care. Covered under your HPN HMO health plan benefits. No appointment necessary, and copays are usually $10 or less. Learn more at ***NowClinic.com*** or NowClinic® app.

United Concordia

For more information on United Concordia resources, visit ***www.unitedconcordia.com***

Chomper Chums

Free app teaches kids about brushing their teeth and making healthy choices. This award-winning app makes brushing fun for kids.

Dental Health Center

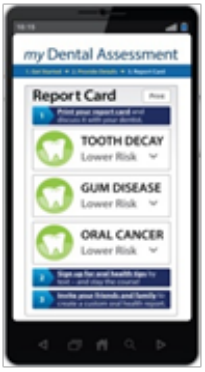
With a host of resources aimed at promoting oral and overall health, the online Dental Health Center provides helpful insights on everything from the basics of brushing and flossing to dental emergency information, resources on nutrition, and how a healthy mouth influences a healthy body.

My Dental Benefits

This is United Concordia's online member portal. Members can create a private account to access information on their plan, print additional ID cards, and find answers to common questions. Below is a link to a short video for My Dental Benefits on How to Create an Account:

http://embed.vidyard.com/share/zRvJtMAtR4P7EFRm29zR9r

My Dental Assessment



This free online tool helps identify oral health risks and shows how your lifestyle factors and medical conditions impact the health of the mouth. When finished, a printable report card is generated for you to easily take to your dentist to review at your next appointment.

IBEW Local 18-Sponsored Health Plans

Anthem Blue Cross

For more information on Anthem resources, visit ***www.anthem.com/ca/ibewlocal18***

NEW! Polarized Lenses Through VSP

All IBEW Local 18-sponsored health plans through Anthem Blue Cross will cover polarized lenses through VSP. Polarized lenses will be covered in full with a $0 copay from VSP in-network providers.

Online health resources

Includes resources and videos to target specific health groups such as children, women, men and seniors.

24/7 NurseLine

Find quick answers to health questions anytime day or night.

Online access to plan information

Understand your plan benefits, the status of a claim, etc.

LiveHealth Online

A convenient way for retirees to interact with a U.S. board-certified doctor via live, two-way video on your computer or mobile device. LiveHealth Online visits are secure, safe and available at $0 co-pay, which is the same level as an in-nework doctor visit.

Anthem LiveHealth Online also includes visits to certified psychologists and therapists. LiveHealth Online Psychology visits are covered at $0 co-pay, which is the same level as traditional LiveHealth Online visits. Please note that users must be at least 18 years old to use LiveHealth Online Psychology.

Mobile Health Consumer

The Anthem Mobile Health App is included in all IBEW Local 18 Anthem Blue Cross medical plans, and available to all Anthem Blue Cross enrolled retirees and their dependents over age 18. Some features of the app include:

- Mobile access to plan information
- Mobile access to ID cards
- Integration with LiveHealth Online
- Links to find a provider

Body Scan Cervical Spine

The Body Scan benefit available through IBEW Local 18 and Anthem Blue Cross also includes a comprehensive cervical spine scan.

Diabetes Prevention Program

A 12-month program to help at-risk retirees reach health and wellness goals. Elements of the program include: a personal health coach, weekly lessons, and access to a network of weight management programs.

Other Anthem resources

- Health and fitness discounts
- Health Rewards
- 360° Health Programs
- MyHealth@Anthem

Guardian Dental

For more information on Guardian Dental resources, visit www.guardiananytime.com

NEW! Composite Fillings

Composite, white or tooth-colored, fillings will be covered for posterior teeth on the Guardian PPO dental plan. This new benefit will be covered as a basic service (90% of PPO fee in-network, 80% of customary and reasonable charges out-of-network)

Online resources

Understand your dental benefits, look up the status of a claim, find forms and plan materials, and estimate your dental costs.

Provider app

Download on your smartphone or mobile device to find a provider anytime you need to.

Medicare Coverage

This section explains the different Medicare plans and how they relate to your LADWP-sponsored or IBEW Local 18-sponsored health plans.

Special Notes for Retirees Age 65 or Older:

- **Enroll in Medicare Part B by age 65.** By age 65, you must be enrolled in Medicare Part B for LADWP-sponsored health plans, and Medicare Parts A and B for IBEW Local 18-sponsored health plans, and show proof of enrollment, to avoid losing your LADWP- or IBEW Local 18-sponsored health plan. If you are 65 or older and you or your spouse/domestic partner fail to enroll in or maintain your Medicare coverage, you may incur additional fees. If your Medicare status changes after age 65, you must immediately provide the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center with written confirmation of the change. See **pages 51-56** for Medicare details.
- **Retirees may be eligible for Medicare Part B premium reimbursement.** When you enroll in Medicare Part B at age 65, you may be eligible for reimbursement of the premium that's taken out of your Social Security check if you have enough LADWP subsidy left over after your health premium has been deducted. Contact the LADWP Health Plans Administration Office to find out if you're eligible, and obtain the forms to request the reimbursement. See **pages 52-53** for details.

Providing Proof of Medicare Coverage

Proof of Medicare coverage must be provided in the form of:

- Copy of Medicare Card
- Copy of Awards Letter

It is your responsibility to inform the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center of any change in Medicare status by submitting proof from the Centers for Medicare and Medicaid Services (CMS).

- **Medicare Part B Reimbursement – Annual Enrollment.** You are required to request enrollment in Medicare Part B reimbursement on an annual basis. Failure to do so will result in benefit termination. See **pages 52-54** for details.
- **LADWP can directly pay your Medicare Part B premiums.** You can make arrangements for your Medicare Part B premiums to be paid directly to the Centers for Medicare and Medicaid Services (CMS). To start this process, contact the LADWP Health Plans Administration Office at **(213) 367-2023** when you receive the Notice of Premium Payments Due statement from CMS to request the necessary form to enroll in group payment. It is also recommended that you call the LADWP Health Plans Administration Office a couple of days after you mail the documents to confirm receipt. See **pages 53-54** for details.
- **Forward Medicare Part B premium documentation received from Social Security to LADWP.** Any communications you receive from Social Security regarding your and/or your spouse's Medicare Part B premium should be forwarded immediately to the LADWP Health Plans Administration Office.
- **Medicare-eligible participants have Medicare Part D prescription drug coverage.** If you or your dependent is eligible for Medicare and enrolls in an LADWP-sponsored medical plan, your prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan that is offered through LADWP. If you receive a bill for a premium surcharge for Medicare Part D, **YOU MUST PAY THE PREMIUM SURCHARGE. IT IS YOUR RESPONSIBILITY TO PAY THIS. FAILURE TO PAY WILL RESULT IN LOSS OF COVERAGE**.

IMPORTANT: You should not enroll in an Individual Medicare Prescription Drug Plan on your own. If you do, you will lose your LADWP-sponsored prescription drug and medical coverage, and you will lose your LADWP subsidy. See **page 55** for details.

Maintaining LADWP-Sponsored or IBEW Local 18-Sponsored Health Coverage with Medicare

If you are retired and age 65 or over, and you (and your spouse age 65 or older) would like to continue your LADWP-sponsored or IBEW Local 18-sponsored health plan, you must follow these steps:

If You're Enrolled in...	What It Is	What to Do to Keep Your Sponsored Health Coverage	Important Things to Remember
Medicare Part B	Medical Insurance	> Present proof of enrollment in Medicare Part B to the LADWP Health Plans Administration Office > Complete the Medicare application for the following plans: — Kaiser Senior Advantage — UnitedHealthcare Medicare Advantage — Health Plan of Nevada Senior Dimensions	It is necessary to file this proof of Medicare Part B coverage and provide proof prior to reaching age 65 to avoid cancellation of your LADWP-sponsored health plan.
Medicare Parts A & B	Hospital and Medical Insurance	**LADWP-sponsored plans:** Submit a copy of your Medicare card and complete the Medicare application for the following plans: — Kaiser Senior Advantage — UnitedHealthcare Medicare Advantage — Health Plan of Nevada Senior Dimensions **IBEW Local 18-sponsored plans:** Must submit a copy of your Medicare A and B card to maintain coverage in IBEW Local 18-sponsored Anthem Blue Cross HMO and PPO plans	> LADWP requires that you enroll in Medicare Part B only. > LADWP does not recommend that you enroll in Medicare Part A, unless it is premium-free. > Provide proof of Medicare to LADWP Health Plans Administration Office. > IBEW Local 18-sponsored HMO and PPO Plans require Medicare Parts A and B.
Medicare Part D	Prescription Drug Coverage	If you're enrolled in an LADWP-sponsored medical plan, your prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan. The plan benefits offered through LADWP or IBEW Local 18 are better than most Part D plans available to Medicare-eligible individuals. You should not enroll in an Individual Medicare Prescription Drug Plan on your own. **Retirees who receive a bill for a premium surcharge for Medicare Part D are responsible to pay the premium surcharge; failure to pay will result in a loss of coverage.**	If you enroll in a Medicare Part D plan on your own, you will lose your LADWP-sponsored or IBEW Local 18-sponsored prescription drug and medical coverage as well as your LADWP subsidy.

Medicare Part A (Hospital Insurance)

Medicare Part A (hospital insurance) covers some inpatient hospital care and limited care in a skilled nursing facility.

Eligibility for Medicare Part A

To be eligible for Medicare Part A with no premium rate, you must:

- Have satisfied the federal requirements for work covered by Social Security (accrued at least 40 quarters of credits with Social Security),
- Be a citizen or permanent resident of the United States, and
- Have a current domestic address (no P.O. Box).

You can receive Part A at age 65 if you are already receiving retirement benefits from Social Security or the Railroad Retirement Board. Persons who qualify for a monthly Social Security check are automatically enrolled in Medicare Part A.

Note: LADWP does not pay for Medicare Part A.

For IBEW Local 18-sponsored plans, when you turn 65 you must be enrolled in both Medicare A and B to avoid losing coverage. Dependents are not required by the plan to have A and B until the retiree is 65.

What's First: Medicare or LADWP?

Medicare is primary and your LADWP-sponsored health plan is secondary with LADWP's UnitedHealthcare Medicare Advantage HMO plan (with Medicare Part B only), the Health Plan of Nevada (with Medicare Part B only) and the UnitedHealthcare PPO Plan. For Kaiser, UnitedHealthcare and Health Plan of Nevada, once you provide the LADWP Health Plans Administration Office with your Medicare information, you cannot use Medicare on its own. Using Medicare on its own will cause your LADWP-sponsored health plan to end.

If you or your spouse have Medicare Part A only or Part B only, then you must file your medical claim (for facility services or physician services, respectively) with Medicare first. Once you or your provider (facility or physician) have received the Medicare Explanation of Benefits (EOB), the claim and the EOB must be submitted to UnitedHealthcare or Health Plan of Nevada for secondary payment. The Medicare EOB is required in order for UnitedHealthcare or Health Plan of Nevada to process the claim as secondary. This does not apply if you enrolled in an HMO plan with both Medicare Parts A and B.

For more information on the health plans available to retirees, see **page 13**.

What's First: Medicare or IBEW Local 18 Anthem Blue Cross?

When you are enrolled in Anthem Blue Cross, Medicare is primary and Anthem is secondary.

Your claims get filed with Medicare first. Once you or your provider (facility or physician) have received the Medicare Explanation of Benefits (EOB), the claim and EOB need to be submitted by your provider to Anthem Blue Cross for secondary payment.

Medicare Part B (Medical Insurance)

All retirees and dependent spouses age 65 and over, or otherwise eligible for Medicare Part B, must be enrolled in Medicare Part B to remain in an LADWP-sponsored health plan.

For IBEW Local 18-sponsored plans, when you turn 65 you must be enrolled in both Medicare Parts A and B to avoid losing coverage. Dependents are not required by the plan to have A and B until the retiree is 65.

Medicare Part B (medical insurance) covers medical and surgical services provided by a physician, diagnostic X-ray and laboratory tests, outpatient hospital services, ambulance transportation, prosthetic devices, medical equipment and other services. Medicare Part B pays 80% of the allowable charges after the annual deductible (currently **$183**) has been met. See your Medicare handbook or contact your local Social Security office for information regarding Medicare coverage.

Eligibility for Medicare Part B

You are eligible for Medicare Part B if:

- You are a United States resident, a U.S. citizen, or an alien admitted for permanent residence with at least five years' residency.
- You also must have a current domestic address (no P.O. Box).

You must contact your local Social Security office to enroll in Medicare Part B. The current standard monthly premium for Medicare Part B is currently **$134** (effective January 1, 2018).

Paying for Your Medicare Part B Coverage

	How Medicare Part B Premiums Are Paid	How to Get Reimbursed for Your Medicare Part B Premiums
If you receive a Social Security check	Medicare Part B premiums are automatically deducted from your Social Security check.	If you are eligible to be reimbursed by LADWP for your Medicare Part B premiums: > It is your responsibility to request reimbursement at the time of eligibility by completing a deduction authorization form and submitting the required documents (copy of Medicare Card and Award Letters). > Reimbursement will begin the first of the following month after the LADWP Health Plans Administration Office receives your request and supporting documents. LADWP will not reimburse retroactively.
If you *do not* receive a Social Security check	You may make arrangements in writing to have LADWP pay Medicare Part B premiums directly to the Centers for Medicare and Medicaid Services (CMS). The CMS will send a Notice of Premium Payment Due for you or your spouse.	To make group payment arrangements you must: Provide LADWP with the original Notice of Premium Payment Due from Medicare as soon as you receive it, and mail it to: **LADWP Health Plans Administration Office** P.O. Box 51111, Room 564 Los Angeles, CA 90051-0100 You must request to be enrolled in group payment by completing a deduction authorization form and submitting the Notice of Premium Payment Due. The Notice of Premium Payment Due must be submitted before the due date. Failure to do so will result in termination of your Medicare and health plan coverage. LADWP will not pay retroactively.

Take Action: Reimbursement of Medicare Part B Premiums

Reimbursement of Medicare Part B is not automatic; you must request it in writing by completing a deduction authorization form and submitting the required supporting document(s) to the LADWP Health Plans Administration Office.

Reimbursement will begin the first of the following month after the LADWP Health Plans Administration Office receives your request and supporting documents.

Tip! Verify Eligibility for Reimbursements

After submitting required documents for reimbursement, contact the LADWP Health Plans Administration Office to confirm that your paperwork has been received.

Eligibility for Medicare Part B Premium Reimbursement

You and your spouse may be eligible for the LADWP's quarterly Medicare Part B reimbursement if you are:

- A retired employee (surviving and eligible spouses are not eligible for Medicare Part B reimbursements),
- Enrolled in Medicare Part B, and
- Receiving a monthly Social Security check, and
- Receiving an LADWP subsidy toward the cost of your health care plan that is equal to or greater than the cost of your health plan premium plus the cost of your Medicare Part B.

Medicare Part B reimbursement eligibility is not guaranteed. Please check with the LADWP Health Plans Administration Office to determine eligibility.

Medicare Part B Reimbursement Checks

Medicare Part B reimbursement checks are mailed quarterly to eligible retirees. Dates are subject to change, and checks are not guaranteed to be mailed by any certain date.

The Secretary of the Department of Health and Human Services has directed that all organizations comply with the mandatory insurer law (Public Law 110-173; Section 111). It requires our health plan to report information that the Secretary requires for purposes of coordination of benefits between your health plan and Medicare. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on our health plan to collect the Medicare Health Insurance Claim Number (HICN) or Social Security number (SSN) from you and your family members and submit them to Medicare.

If this information is not already on file with the LADWP Health Plans Administration Office, Medicare HICNs and SSNs will likely be requested in order to meet the requirements of this law. Unfortunately, if you or your family member is a Medicare beneficiary and you do not provide the requested information, the affected member may be violating obligations to assist Medicare in coordinating benefits. Please assist us by providing this information, if requested.

Medicare Part B Reimbursement Reminders

- Reimbursement of Medicare Part B is not automatic. It is your responsibility to enroll in or request the LADWP to renew your Medicare Part B reimbursement. Annual Award Letters should be received in the LADWP Health Plans Administration Office on or before December 31 of each year to ensure continued benefits.
- Income Related Monthly Adjustment Amount (IRMAA) — It is imperative that you and your spouse provide the annual IRMAA notification to the LADWP Health Plans Administration Office by December 31 of each year. Failure to do so will result in benefit termination.
- LADWP will not make retroactive payments or reimbursements.

Any communications you receive from Social Security regarding your and/or your spouse's Medicare Part B premium should be forwarded immediately to the LADWP Health Plans Administration Office.

Group Payment

If you do not receive a Social Security check, you may request LADWP to pay your Medicare Part B premiums on behalf of you and your spouse. Please contact the LADWP Health Plans Administration Office to request the necessary form.

While LADWP continues its efforts to verify eligibility of your dependent(s), we must use your SSN for the process as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We understand and handle retiree information according to those requirements, which is included as part of LADWP HIPAA Policies and Procedures, Group Health Plan Amendments.

Medicare Part D (Prescription Drugs)

Medicare Creditable Coverage Notice

Important Notice for Medicare-Eligible Retirees from LADWP About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it for your records. This notice contains important information about your current prescription drug coverage through your LADWP-sponsored or IBEW Local 18-sponsored health plan and about your options for enrolling in an individual Medicare prescription drug plan. If you are enrolled in an LADWP-sponsored health plan, your current prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan. If you are enrolled in an IBEW Local 18-sponsored medical plan, your current prescription drug coverage is not an enhanced Medicare Part D Prescription Drug Plan, but it is "creditable coverage."

There are two important things you need to know about your current prescription drug coverage through LADWP-sponsored or IBEW Local 18-sponsored plans and the individual Medicare prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join an individual Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- If you're enrolled in an LADWP-sponsored health plan, your prescription drug coverage is an enhanced Medicare Part D Prescription Drug Plan. LADWP has determined that the prescription drug coverage offered by LADWP-sponsored and IBEW Local 18-sponsored health plans, on average for all plan participants, is expected to pay out as much as individual Medicare prescription drug coverage pays and is therefore considered creditable coverage.

Remember: Once you reach the "catastrophic coverage" level, your costs will go up. The catastrophic coverage level is reached once a Medicare beneficiary spends $5,000 out of pocket for 2018. The member will pay $3.30 for generic, $8.25 for brand-name or 5%, whichever is greater.

Tip!

When you have a choice of generic or brand-name prescription drugs, generic drugs are the more cost-effective option.

You are required to enroll in a Medicare Part D Prescription Drug Plan when you first become eligible for Medicare (or face higher premiums if and when you eventually enroll in an individual Medicare Part D plan) unless you are already enrolled in a plan that provides you with creditable coverage. Because your existing coverage through an LADWP-sponsored or IBEW Local 18-sponsored health plan is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to drop this coverage and join an individual Medicare drug plan. **Retirees are responsible for paying the premium surcharge for Medicare Part D. Failure to pay will result in loss of coverage.**

When Can You Join an Individual Medicare Drug Plan?

You can join an individual Medicare drug plan when you first become eligible for Medicare, and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join an individual Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join an Individual Medicare Drug Plan?

If you decide to enroll in an individual prescription drug plan through Medicare, you will lose your LADWP-sponsored or IBEW Local 18-sponsored prescription drug and health coverage, as well as your LADWP subsidy.

When Will You Pay a Higher Premium (Penalty) to Join an Individual Medicare Drug Plan?

If you drop or lose your current prescription drug coverage with LADWP or IBEW Local 18 and don't join an individual Medicare drug plan within 63 days after your current coverage ends, you may pay a higher premium (a penalty) to join an individual Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the individual Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have individual Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information

For further details about this notice or your current prescription drug coverage, contact the LADWP Health Plans Administration Office for further information.

Note: You will get this notice each year. You will also get it before the next period you can join an individual Medicare drug plan, and if coverage through LADWP changes. You also may request a copy of this notice at any time.

For details about your options under individual Medicare Prescription Drug Coverage:

More detailed information about individual Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about individual Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- Call **(800) MEDICARE [(800) 633-4227]**. TTY users should call **(877) 486-2048**.

If you have limited income and resources, extra help paying for individual Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call **(800) 772-1213**; TTY: **(800) 325-0778**.

Remember: Keep This Creditable Coverage Notice

If you decide to join one of the individual Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you're required to pay a higher premium (a penalty).

Date: April 2018

Name of Entity/Sender: Los Angeles Department of Water & Power

Contact–Position/Office: LADWP Health Plans Administration Office

Address: 111 N. Hope Street, Room 564
Los Angeles, CA 90012

Phone Number: (800) 831-4778 or **(213) 367-2023**

Continuing Coverage with COBRA

The following notice applies to all participants covered under a group health plan maintained by LADWP or IBEW Local 18. This notice generally explains group health insurance continuation coverage, when it may become available and what you need to do to protect your right to receive it. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. Please note that the Employee Assistance Program (EAP) will remain available to COBRA program participant(s) if elected and paid for.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Health and/or dental coverage ends on the last day of the month in which your employment with LADWP ends. You may be able to extend your health and/or dental coverage with COBRA as outlined below.

As initially enacted in 1985 under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employers are required to provide employees and their covered dependents the opportunity to elect continued group health coverage upon the occurrence of certain "qualifying events." Under this federal law, LADWP is required to offer this opportunity for a temporary extension of health coverage called "continuation coverage" at group rates. This coverage, however, is only available when coverage is lost due to certain qualifying events. Should an actual qualifying event occur in the future, the plan administrator will send you additional information and the appropriate election notice at that time.

Qualifying Events for Covered Spouses

- Death of covered retiree
- Divorce from a covered retiree or, if applicable, legal separation from the covered employee or covered retiree
- Your spouse becomes enrolled in Medicare benefits (Part A, Part B or both)

Qualifying Events for Covered Children

- The death of the parent-employee
- Parent's divorce or, if applicable, legal separation
- The parent-employee becomes enrolled in Medicare benefits (Part A, Part B or both)
- Covered dependent ceases to be an eligible child under the terms of the LADWP group health plan

Qualifying Events Defined Under COBRA

A COBRA qualifying event occurs when an event listed in the COBRA statute occurs, and the event causes a covered employee, a covered spouse or a covered dependent to lose health insurance under an employer's group health plan. To lose health insurance means the individual ceases to be covered under the same terms and conditions they were covered under before the event happened.

Important Notification Requirements Under COBRA

Under COBRA, a covered employee, a covered spouse or other covered family member has the responsibility to notify the appropriate plan administrator (LADWP or IBEW Local 18) of any qualifying event, including death, divorce, legal separation, or when a dependent ceases to be a dependent under the LADWP Health Plans Administration or IBEW Local 18-sponsored plans. This notification must be made within 60 days from the date of such event.

If this notification is not completed within the 60-day notification period, the right to continuation coverage is forfeited.

Eligibility Under COBRA

You, your spouse and your children are eligible for COBRA continuation if you and your dependents were covered under the plan on the day before the qualifying event. Once the election to continue coverage has been made, additional dependents may be added following the same guidelines specified on **pages 10-11** of this guide. You, your spouse and your dependents have independent election rights and must make an election for continuation coverage to become effective. If you have a covered dependent whose legal residence is different from yours, you must provide written notification to the appropriate plan administrator (LADWP or IBEW Local 18) so that a notice can be sent to them as well. Should you add more children in the future, notice to the covered employee and spouse at this time will be deemed notification to the newly covered dependent.

Domestic Partners Are Not Eligible for COBRA

While LADWP and IBEW Local 18-sponsored group health plans allow domestic partners to be covered, if a domestic partner loses group health insurance as a result of one of the listed qualifying events under the COBRA statute, the domestic partner will not be offered the opportunity to continue the group health insurance. This is because COBRA is regulated under federal law. Under federal rules, the term "spouse" does not include domestic partners.

Election Period and Coverage

Once the appropriate plan administrator (LADWP or IBEW Local 18) has been notified of a qualifying event, the formerly covered individual(s), also known as "qualified beneficiaries," are notified of their right to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days to elect continuation coverage. The 60-day election window is measured from the date of notification. This is the maximum period allowed to elect continuation coverage, as the plan does not provide an extension of the election period beyond what is required by law.

If a qualified beneficiary does not elect continuation coverage within the 60-day election period, then rights to continue health insurance will end, forfeiting any rights and protections that were afforded to the participant under the COBRA law. Once a qualified beneficiary elects continuation coverage, he or she has up to 45 days to pay the first premium. You may not have a lapse in coverage. Premiums will be due back to your original termination date.

The length of continuation coverage is:

- 18 months for formerly covered employees
- 36 months for formerly covered spouses and/or children for events other than the employee's termination of employment or reduction in hours

California COBRA AB 1401

California COBRA AB 1401 (effective September 1, 2003) stipulates that an employer shall offer an insured who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the insured's continuation coverage begins if the insured is entitled to less than 36 months of continuation coverage under COBRA.

Continuation Coverage from 18 Months to 29 Months

Two situations will extend continuation coverage beyond the coverage date if applicable. The 18 months of continuation coverage will be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries provided that the:

- Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act as of the date of the qualifying event or at any time during the first 60 days of continuation coverage. It is the qualified beneficiary's responsibility to obtain the disability determination from the Social Security Administration and provide a copy of the Social Security Disability determination to the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center (for Anthem Blue Cross plans) within 60 days of the date of determination and before the original 18 months of continuation coverage expires; or
- Secondary event takes place (divorce, legal separation, death, Medicare entitlement or a dependent ceasing to be a dependent). If a secondary event occurs, then the original 18 or 29 months of continuation coverage will be extended to 36 months from the date of the original qualifying event date for dependent qualified beneficiaries. If a secondary event occurs, it is the qualified beneficiary's responsibility to notify the LADWP Health Plans Administration Office or IBEW Local 18 Benefit Service Center in writing within 60 days from the secondary event, and within the original 18-month continuation coverage timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage.

Monthly Premiums Under COBRA

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since a COBRA participant is required to pay the entire cost for health insurance plus a 2% administration fee for regular federal COBRA, but that goes up to 10% for California COBRA. Premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The initial premium payment must be paid within 45 days of the election. You may not have a lapse in coverage. Premiums will be due back to your original termination date.

Premiums for successive periods of coverage are due on the first of each month, but a qualified beneficiary has a 30-day grace period to pay the monthly premium, and the envelope must be postmarked within or by the end of the grace period. The 30-day grace period is measured after the due date (first of the month). If the monthly premium is not paid by the due date or within the 30-day grace period, the continuation coverage elected is cancelled. Monthly premiums could be adjusted during the continuation period if the applicable premium amounts change.

Medicare Entitlement Under COBRA

If an individual is on continuation coverage and becomes entitled to Medicare after the date of COBRA election, the COBRA coverage can be terminated. However, as clarified under the final COBRA regulations, if an individual has been entitled to Medicare and becomes eligible for COBRA continuation, the individual is allowed to have both.

Cancellation of Continuation Coverage Under COBRA

Continuation coverage will terminate prior to the expiration of the continuation period (18 or 36 months) for any of the following reasons:

- LADWP ceases to provide any group health plan to any of its employees;
- Any required monthly premium for continuation coverage is not paid in a timely manner. Monthly premiums are due on the first day of each month. In addition, qualified beneficiaries have a maximum 30-day grace period after the due date in which to pay these monthly premiums;
- A qualified beneficiary notifies the LADWP Health Administration Office to cancel continuation coverage and request a cancellation form;
- A qualified beneficiary, after the date of election, becomes entitled to Medicare;
- A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability, and a final determination has been made that the qualified beneficiary is no longer disabled;
- For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants;
- A qualified beneficiary enrolls in another group health plan.

Conversion After COBRA

Some health and dental plan providers offer the opportunity to convert to an individual plan (versus group coverage through LADWP) following cancellation of COBRA coverage.

Plan providers that offer conversion to individual coverage:

- Kaiser HMO
- UnitedHealthcare HMO
- Health Plan of Nevada HMO
- IBEW Local 18-sponsored Anthem Blue Cross health plans

Plan providers that do not offer conversion to individual coverage:

- Delta Dental
- United Concordia
- IBEW Local 18-sponsored Guardian Dental plans

However, members can contact United Concordia or IBEW Local 18-sponsored Guardian Dental plans after COBRA is exhausted and request an individual plan. For more information, please contact member services for your health or dental provider.

This section is a summary of the COBRA federal and state regulations. For detailed exceptions, conditions and exclusions, please contact:

LADWP Health Plans Administration Office
P.O. Box 51111, Room 564
Los Angeles, CA 90051-0100
(213) 367-2023 or **(800) 831-4778**

IBEW Local 18 Benefit Service Center
9500 Topanga Canyon Blvd.
Chatsworth, CA 91311
(800) 842-6635 or **(818) 678-0040**

Health Care Notices

Health Care Reform

The Affordable Care Act (ACA), also known as the health care reform law, was signed into law in 2010. While the law was created to expand access to health care coverage, control health care costs and improve health care quality and coordination, it also impacts employer-sponsored health plans. In the past, you've seen certain changes to your benefits. Examples include receiving the Summaries of Benefits and Coverage (SBC) documents or allowing adult children up to age 26 to enroll in LADWP-sponsored or IBEW Local 18-sponsored plans.

The Individual Mandate*

The biggest impact to U.S. residents is a provision called the individual mandate. This rule requires all U.S. residents, with few exceptions, to enroll in a qualified health plan or pay a penalty. You need to know that LADWP-sponsored and IBEW Local 18-sponsored health plans are "qualified" under the ACA. This means if you enroll in an LADWP-sponsored or IBEW Local 18-sponsored health plan, you satisfy the individual mandate and you won't have to pay a penalty. If you don't enroll in an LADWP or IBEW Local 18-sponsored health plan or another qualified health plan, you may be responsible for paying a penalty. Another qualified health plan could include a spouse's plan or a plan purchased through the Health Insurance Marketplace. If you don't enroll in a qualified health plan for 2017, you'll pay the higher of these two following amounts:

- 2.5% of your yearly household income.
(Only the amount of income above the tax filing threshold, about $10,000 for an individual, is used to calculate the penalty.) The maximum penalty is the national average premium for a bronze plan.

- $695 per person for the year ($347.50 per child under 18). The maximum penalty per family using this method is $2,085. The penalty increases each year until 2018, when it will be the greater of $695 or 2.5% of taxable income. In 2018 and beyond, smaller increases are expected.

*Penalty is only applicable from July 1, 2018 – Dec. 31, 2018

Notice of Grandfathered Status

The Los Angeles Department of Water and Power (LADWP) believes all LADWP-sponsored health plans, except the UnitedHealthcare PPO Plans and IBEW Local 18-sponsored health plans for LADWP active employees, are "grandfathered health plans" under the Affordable Care Act (ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. As health plans that are grandfathered, LADWP-sponsored health plans may not include certain consumer protections of the ACA that apply to non-grandfathered plans — for example, certain provisions affecting benefits for emergency services. However, grandfathered health plans must comply with certain other consumer protections in the ACA — for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections don't apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **(866) 444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and don't apply to grandfathered health plans.

Improper Use of Benefits

Retirees who receive benefits for themselves or their ineligible dependents from an LADWP-sponsored or IBEW Local 18-sponsored health or dental plan based on a false, deceptive or otherwise improper act may have their health or dental plan cancelled and may be considered ineligible for enrollment in LADWP-sponsored or IBEW Local 18-sponsored health and dental plans. In addition, retirees will be billed for any LADWP subsidy paid for ineligible dependents.

Where to File Complaints — Department of Managed Health Care

The LADWP-sponsored and IBEW Local 18-sponsored health and dental plans are licensed under a California law known as the Keene Care Service Plan Act of 1975, which is administered by the Department of Managed Health Care (DMHC). If you wish to file a complaint against your health or dental plan with the DMHC, you may do so only after you have contacted your health or dental plan member service and used the plan's grievance process. However, you may immediately file a complaint with the DMHC if the health or dental plan has not satisfactorily resolved your grievance within 30 days from filing a formal complaint with the health or dental plan. The DMHC toll-free telephone number is **(800) 400-0815**; the DMHC website is **www.dmhc.ca.gov.**

This Brochure Is Not a Contract

For detailed exceptions, conditions or exclusions, contact:
LADWP Health Plans Administration Office
111 North Hope Street, Room 564
Los Angeles, CA 90012
Phone: **(213) 367-2023**

Remember, it is your responsibility to complete all of the necessary forms for the health or dental care plan of your choice and return them to the LADWP Health Plans Administration Office. Changes in your health or dental plan require new forms to be filled out. If you have any questions regarding the Department of Water and Power health and dental plans, you may call **(213) 367-2023** or **(800) 831-4778**. For more information regarding IBEW-sponsored Local 18 medical and dental plans, call the IBEW Local 18 Benefit Service Center at **(818) 678-0040** or **(800) 842-6635**.

Contact Information

Health and Dental Plan Contact Information

LADWP-Sponsored		
LADWP Health Plans **Administration Office** **111 N. Hope Street, Room 564** **Los Angeles, CA 90012**	**(213) 367-2023** **(800) 831-4778** **HealthPlans@ladwp.com**	**https://eBenefits.ladwp.com**
Carrier	**Phone**	**Website**
Health Plan of Nevada	Pre-65: (800) 777-1840 Post-65: (800) 650-6232	Pre-65: www.myhpnonline.com Post-65: www.seniordimensions.com
Kaiser Permanente	(800) 464-4000	www.kp.org
United Concordia Dental (DHMO and PPO)	(866) 851-7568	www.unitedconcordia.com
UnitedHealthcare HMO	(800) 624-8822	www.myUHC.com
UnitedHealthcare PPO	(866) 783-7481	www.myUHC.com
UnitedHealthcare HMO Medicare Advantage	(800) 457-8506	www.UHCretiree.com

IBEW Local 18-Sponsored		
IBEW Local 18 **Benefit Service Center** **9500 Topanga Canyon Boulevard** **Chatsworth, CA 91311**	**(800) 842-6635** **(818) 678-0040** **local18@mybenefitchoices.com**	**www.mybenefitchoices.com/local18**
Carrier	**Phone**	**Website**
Anthem Blue Cross HMO and PPO	(800) 227-3771	www.anthem.com/ca/ibewlocal18
Anthem Blue Cross Owens Valley PPO	(800) 759-3030	www.anthem.com/ca/ibewlocal18
Guardian Dental	PPO: (800) 541-7846 DHMO: (800) 273-3330	www.guardiananytime.com

Additional Contact Information

Department	Phone
Local 721 Dental Zenith American Solutions	(877) 802-9740
L.A. City Employee Benefits	(213) 978-1655 (800) 778-2133